USAID | MADAGASCAR
FROM THE AMERICAN PEOPLE

SANTÉNET ANNUAL REPORT

October 1, 2005 to September 30, 2006

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CONTENTS

ACRONYMS

ABACUS	Automated Business Accounting Connection System
ACT	Artemisinin-based Combination Therapy
BCC	behavior change communication
CBDA	Community-based distribution agents
CBHC	Community-based health center
CCM	Country Coordination Mechanism
CCR	Contraceptive Coverage Rate
CDC	Commune Development Committee
CYP	Couple Years of Protection
DAF	Director of finance and administration
DDM	Data for decision making
DHFPS	District Health and Family Planning Services
DHS	Demographic Health Study
DM	Distrika Mendrika
DQD	Data Quality Control
EDC	Economic Development SubCommittee
ENA	Essential Nutrition Actions
EnDC	Environmental Development SubCommittee
ERI	Eco-Regional Alliance
EPI	Expanded Program on Immunization
FBO	Faith-based organization
FISA	Malagasy International Planned Parenthood Federation affiliate
FP	Family planning
GAVI	Global Alliance for Vaccines and Immunization
GED	Generic Essential Drugs
GOM	Government of Madagascar
HCP	Health Communication Partnership
HIP	Hygiene Improvement Project

HPE	Health, Population, and Environment
IACC	Inter-agency Coordination Committee
IEC	information, education, communication
IECSMU	IEC and Social Mobilization Unit
IP	Infection prevention
IRH	Institute for Reproductive Health (Georgetown University)
ITNs	Insecticide-treated nets
IUD	Intra-uterine device
KM	Kaominina Mendrika
KOKOME	Kaominina Mendrika Committee
LTPM	Long-term permanent methods
MAR	Monthly Activity Report
eMCDI	Medical Care Development International
MCHW	Mother and Child Health Week
MIS	Management Information System
MLM	Middle Level Management
MNT	Maternal and Neonatal Tetanus
MOU	Memorandum of Understanding
MSI	Marie Stopes International
ES/NACC	Executive Secretariat of the National AIDS Control Commission
NCNP	National Community-based Nutrition Program
NGOs	Nongovernmental organizations
NHCMC	Health Communication and Mobilization Committee
NNO	National Nutrition Office
ONN	Office of National Nutrition
PhaGDis	Pharmacie Gros District (district level pharmacy wearhouse)
PLHAs	People living with HIV/AIDS
PLeROC	Platform of Religious Leaders
PQI	Performance Quality Improvement
PMP	Performance Monitoring Plan
PRSP	Poverty Reduction Strategy Paper
PRSP	World Health Organization
PSI	Population Services International
PSPs	Policies, Standards and Protocols
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RED	Reach Every District
RH	Reproductive Health
RHFPD	Regional Health and Family Planning Directorates
RIS	Residual Indoor Spraying (of insecticides)

RHIS	Routine Health Information System
RRI	Rapid Results Initiative
SDC	Social Development Subcommittee
SDM	Standard Days Method
SMP	Social marketing products
SMU	Safe Motherhood Unit
ST	support technicians
STIs	sexually transmitted infections
TMC	Tanána Mendrika Committee
TOT	Training of trainers
TRG	Training Resources Group
WASH	Water, Sanitation, and Hygiene
ABACUS	Automated Business Accounting Connection System
ACT	Artemisinin-based Combination Therapy
BCC	behavior change communication
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CBHC	Community-based health center
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EXECUTIVE SUMMARY

USAID/Madagascar has contributed to the development and improvement of the populations' health status in Madagascar for more than a decade. Santénet represents the latest phase of USAID's assistance to the Government of Madagascar aimed at improving the health and the well-being of the Malagasy population. During this period, Santénet continued its assistance the Ministry of Health and Family Planning (MOH/FP) by focusing activities on USAID's four intermediate results:

1. Increasing the Demand for Health Products and Services
2. Increasing the Availability of Health Products and Services
3. Improving the Quality of Services Provided
4. Strengthening Institutional Capacities

Building on the first year's foundation, Santénet's second year implemented the first phase of its comprehensive commune-level activities: the *Kaominina Mendrika* (KM) approach was implemented in 81 communes, the Performance and Quality Improvement (PQI) process was applied in 55 rural health centers in these communes, and *mutuelles* (community-based health financing) were introduced in 25 communes. Technical assistance at the national level to the MOH/FP updated policies, improved logistics systems, and improved the functionality and utility of the Health Management Information System (HMIS) of Madagascar — resulting in better access to health care and increased use of health products.

Highlights of this reporting period include:

- Supporting 12 local partners in the implementation of *Kaominina Mendrika* in 81 communes by providing training, information, education and communication (IEC) materials, promotional materials, mass media support and formative supervision. In addition, negotiations have begun, and in some instances been completed, with partners for the second cycle of *Kaominina Mendrika*. Cycle 2 will also introduce a health district-wide approach: *Distrika Mendrika* (DM)
- Contributing to the development of the KM multisectoral approach and assisting other development sectors (economic growth, environment, education, and democracy and governance) to devise ways to use the *Kaominina Mendrika* methodology to achieve their objectives
- Establishing a network of 61 rural radio stations to support community-based programs and disseminate *Kaominina Mendrika* messages
- Introducing the concept and supporting the development and the launch of Madagascar's first Maternal and Child Health Week
- Scaling up the *Ankoay* youth HIV peer education approach to 166 scout troops and adapting the model to high schools and sports clubs to increase its reach

- Assisting the MOH/FP in improving its Health Information System including the use of data for decision making to better ensure contraceptive security and logistics, function of vaccines cold chains, and expand vaccination coverage
- Introducing *mutuelles* — risk-sharing health financing schemes — to improve access to products and services year-round
- Revising policy norms and procedures to improve the quality of health care services by implementing the PQI approach and training care providers in quality assurance and supervisory techniques.

Initial results of these activities confirm what works and allow us to identify areas of improvement and provide us with guidance on how the project will conduct business in the remaining two years of the project.

The lessons learned during the first two years of implementation are numerous. Overall, they include evidence that simultaneous implementation of complementary approaches creates optimal synergy and greater impact at the commune level. More activities are now being implemented in selected communes.

For the sustainability of demand creation and community mobilization activities, we have learned that the scale up of the *Kaominina Mendrika* approach requires that implementing partners use the approach as a tool to achieve better results where they are already implementing other projects and activities. We have also learned that the implementation of the multisectoral *Kaominina Mendrika* approach requires Flexibility and adaptation in the selection of methodologies, tools, timing and implementing partners. Many partners are now using the KM approach in a number of communes where they work and many have already embraced its use to achieve better results for the environment, health, rural development, education and governance sectors.

In the course of implementing the performance and quality improvement approach, we have learned that District Health and Family Planning Service participation and commitment to activities at the commune level further increase demand, availability and quality of health products and services. We also know now that ensuring the sustainability of the PQI approach requires adaptation for rural CBHCs and seamless integration of the approach into the MOH/FP's quality Assurance System

We now have evidence that building systems for data for decision making can profoundly impact program performance and that community involvement and political support are necessary to effectively promote family planning.

All of these best practices, lessons learned and results could not have been achieved with out the effective collaboration of all partners included in the "Santénetwork". The state of Santénet's network is healthy and growing stronger. Partnership is the foundation of Santénet's activities — be it between public and private sectors, upstream with international partners, or downstream with local organizations. These partnerships are based on mutually understood objectives, complementary areas of expertise, and collaboration to produce greater results.

The details of all activities have been provided in this report, which is structured as follows: The first two chapters offer background information on the Malagasy context and the Santénet project. Chapters 3-6 describe activities undertaken over the course of the year by intermediate result (IR). These chapters describe the activities, recount the challenges to implementation and consider results and impact for each IR. Chapter 7 describes the Santénet Fund subcontracts, grants and disbursements to date. Chapter 8 presents a summary of the completion of planned activities and project progress against the objectives set out in the performance monitoring plan (PMP) and the 2005-06 work plan. Chapter 9 recaps the project's administrative operations for the year, and Chapter 10 describes lessons learned and best practices. Chapter 11 presents perspectives for future activities.

CHAPTER ONE

CONTEXT

GENERAL CONTEXT

POVERTY AND HEALTH STATUS IN MADAGASCAR

Data from the World Health Organization (WHO) in 2001 shows that Madagascar was a distant 159 out of 191 countries ranked by health indicators. Clearly, Madagascar faces serious health problems affecting the social welfare of the population, the national economy and the environment. The Government of Madagascar (GOM) recognized that improving health, nutrition, and food security is essential to the engine that drives economic development. In 2003, the Government of Madagascar developed a national strategy, known as the Poverty Reduction Strategy Paper (PRSP)[1], with the objective of reducing the poverty rate by half over the next 10 years. In its Strategic Theme No. 3, the PRSP considers health conditions to be factors that increase workers' short-term productivity and over the long term, improving health services for women and children will impact their life expectancy and children's physical and mental development. Health objectives in the PRSP include promoting maternal and infant health, implementing essential nutrition activities, reducing infectious and non-infectious diseases, improving food security, and reducing vulnerability to natural disasters.

According to the most recent Demographic Health Study (DHS-2003), infant mortality is 58 per 1,000, the total fertility rate is 5.7 and contraceptive prevalence is 27 percent. Over 50 percent of children under age 5 suffer from malnutrition and over 80 percent of the population has no access to drinking water. Other studies show that despite the relatively low HIV/AIDS prevalence (1-3 percent), Madagascar's STI rate is among the highest in the world, with 21 percent of pregnant women suffering from syphilis (Struminger, 2000) and 76 percent of sex workers having at least one STI (Behets, Frida et al. 2003). In this context of high STI prevalence, HIV/AIDS could spread quickly and disastrously. Therefore, effective and immediate action is urgently needed.

Despite growing investments in health by the GOM from 5 percent in 1998 to 10 percent in 2000, the quality and availability of priority health products and services remain problematic. To improve this situation, the emergence of the private sector in health must be supported; the public sector infrastructure, information and logistics systems must be strengthened; and pre-service and in-service training must be brought up to standards. Furthermore, to ensure the permanence of health products and services, efficient mechanisms for financing and cost recovery must be put in place and the security of essential medications and contraceptives must be ensured through reinforcing and recapitalization of the SALAMA purchasing cooperative.

[1] *Document de Stratégie pour la Réduction de la Pauvreté* (DSRP)

USAID'S ASSISTANCE FOR SUSTAINABLE AND INTEGRATED ECONOMIC DEVELOPMENT

The overall objective of USAID in Madagascar is to promote "Sustainable and Integrated Economic Development" and contribute to the PRSP goal of poverty reduction.

USAID's strategic objectives are aimed at improving good governance, increasing the use and improving the quality of selected health products and services, improving the protection of biologically diverse forest ecosystems, and expanding and strengthening critical private markets.

USAID'S ASSISTANCE FOR HEALTH IMPROVEMENT

USAID's experience shows a strong cause-effect relationship between these strategic objectives and these vital inter-related sectors. USAID would like to contribute to reinforcing innovative approaches that integrate the sectors of food security; health, population, and environment; HIV/AIDS prevention; good governance; information technology and communications; vulnerability to disasters and conflicts; gender equity; and alliances between the public and private sectors.

USAID has demonstrated long-term commitment to improving health status in Madagascar. The APPROPOP project (1993-1998) was designed to increase the number of Malagasy practicing modern family planning. The Jereo Salama Isika project (1999- 2003) sought to decentralize health care, improve the quality of services, and encourage local communities to be responsible for their own health. The Santénet project (2004-2008) is the third phase of USAID's assistance to the Government of Madagascar to improve the health and the well-being of the Malagasy population.

CONTEXT 2005-2006

In October 2005, Santénet's strategic approaches were already well positioned and adopted by the national counterparts: Kaominina Mendrika had been launched in 81 communes; to fight HIV/AIDS, the Ankoay had been initiated with 100 scout troops in nine regions of Madagascar; the Equity Fund had been launched and lessons learned from mutuelles had been gathered; and the Performance and Quality Improvement (PQI) approach had been introduced at the MOH/FP as a key strategy for improving quality of service delivery.

Several key events occurred during this reporting period, improving the environment for implementing Santenet's strategic approaches.

The government's Madagascar Action Plan (MAP), published this year, included four health objectives for 2012 directly linked to three technical areas of Santénet's interventions: family planning, maternal and child health and HIV.

Promising results from the Ankoay scouts initiative were published, positioning Santénet as the preferred partner of the ES/NACC in the fight against HIV/AIDS among youth. Ankoay scouts, Ankoay Sports and Ankoay College were included in the National Strategic Plan 2006-2012 and became the main approach used in Madagascar for any youth-targeted interventions.

Finally, recent changes at the MOH/FP Malaria Control Unit opened more opportunities of partnership with Santénet. Early meetings with this team allowed the project to clearly identify four areas of collaboration: IEC, support to the transition new treatment scheme, logistics improvement, and monitoring and evaluation.

CHAPTER TWO

ABOUT SANTENET

GENERAL AND SPECIFIC OBJECTIVES

Under the implementation of the Government's General Health Policy, the Ministry of Health and Family Planning (MOH/FP) focuses its efforts on the main areas identified in the National Health Policy, which include decentralizing the national health system, improving efficiency of health sector financing, expanding the private sector, promoting community mobilization for health development, protection and promotion, and diseases control.

Building on USAID's previous health projects' achievements, Santénet seeks to assist the MOH/FP to achieve the following intermediate results:

Increasing the Demand for Health Products and Services (Intermediate Result 1). IR1 strives to *increase the demand* for health products and services so as to promote family planning, improve child health, combat malaria, and prevent STIs, including HIV/AIDS. To this purpose, IR1's activities are intended to reinforce community mobilization and IEC/BCC (IR1.1), involve the private sector in health promotion (IR1.2), and target priority biodiversity conservation areas (IR1.3).

Increasing the Availability of Health Products and Services (Intermediate Result 2). The activities of IR2 strive to *increase access* to these services and products. Santénet provides technical support to MOH/FP and to its partners to ensure better availability and access to the necessary services and health products to encourage family planning, to improve child health, to combat malaria, and to prevent STIs, including HIV/AIDS. Specifically, the activities of IR2 will improve the logistics systems in the public sector (IR2.1), support the development of a private sector distribution network for socially marketed products (IR2.2), increase access to priority services for remote populations (IR2.3), improve the nutritional value of agricultural products (IR2.4) and improve water management for agriculture and households (IR2.5).

Improving the Quality of Services Provided (Intermediate Result 3). IR3 is working to *improve the quality* of health services. Better services will help encourage family planning, improve child health, control malaria, and prevent HIV/AIDS. In order to improve the quality of such services, IR3 activities are designed to strengthen and improve the Policies, Standards and Protocols (PSPs) for health services in the public and private sectors (IR 3.1), improve service providers' ability to provide high-quality health services (IR3.2), and introduce operational models for quality assurance (IR3.3).

Strengthening Institutional Capacities (Intermediate Result 4). Overall, IR4 activities will reinforce the health system and support civil society and NGOs to implement health activities in order to promote family planning, improve children's health, fight malaria and prevent STIs, including HIV/AIDS. *Institutional capacity building* comes through the improved collection and use of data for decision making (IR4.1), better access to health information (IR4.2), the ability of NGOs to implement health programs (IR4.3) and the capacity of civil society to be an advocate for public health (IR4.4).

SANTÉNET'S STRATEGIC APPROACH: PARTNERSHIP

In order for Santénet to achieve its objectives and contribute to improving the well-being of the Malagasy people, the project will collaborate closely with partners in the public and private sectors to achieve common health objectives by implementing proven best practices and innovative approaches.

Partnership is the foundation of all activities planned in the framework of the Santénet project. This partnership exists when organizations with common objectives and complementary areas of expertise commit their resources and work together to produce results that would be difficult to achieve alone. The Santénet partnership vision suggests that *synergy* between partners is created based on c*ommon objectives* and built through the partners' contribution of a*dded values* with the goal of achieving better results together.

Partnering with the public sector. Santénet works directly with and for Madagascar's MOH/FP, the National AIDS Control Committee, as well as with other concerned ministries and administrative entities.

Partnering with the private sector. Santénet also collaborates closely with international and local NGOs, private companies, the media, and training institutions that play key roles in promoting health in Madagascar. In addition, through its Santénet Fund, the project will enable local organizations to implement activities that will contribute not only to achieving the health objectives of the program, but also to reinforcing local institutional capacities and thus ensuring the long-term permanence of the program.

Partnering to implement best practices and innovative approaches. To maximize the impact of project resources and build on past efforts, Santénet always strives to follow a highly consultative process for creating consensus among all relevant entities regarding successful models and approaches that should be targeted for replication and scale-up. Instead of developing new models, Santénet builds on lessons learned from previous projects in Madagascar and worldwide to improve existing models and mobilize different partners for their implementation at a larger scale.

Partnering to achieve common objectives. Santénet adds value and fosters synergies with partners around common objectives to improve the well-being of the Malagasy people. While Santénet's main focus is on health, the approach is a multisectoral one that entails collaboration with other important development projects and programs, funded by USAID and other agencies, such as environment, governance, and economic growth.

SANTÉNET'S STRATEGIC APPROACH: NATIONAL AND LOCAL LEVEL INTERVENTIONS

Santénet operates at both the national and local levels to improve indicators. Activities will be implemented at the national level to influence national policies, norms, and procedures that will increase the demand for, increase access to and improve quality of selected health services and products, while building institutional capacity at a ministerial, or central, level. Santénet will also design activities that trickle down to the local level, i.e. the community-based health center (CBHC) and the community, and that ensure that the end beneficiary, the local population in USAID's four intervention provinces — Antananarivo, Toamasina, Toliara and Fianarantsoa — benefits from better information about, better access to, and improved quality of health services and products.

CHAPTER THREE: INTERMEDIATE RESULT 1 (IR 1)

INCREASING DEMAND FOR SELECTED HEALTH SERVICES AND PRODUCTS

INTRODUCTION TO THE INTERMEDIATE RESULT

IR1 strives to *increase the demand* for health products and services so as to promote family planning (FP), improve child health, combat malaria, and prevent sexually transmitted infections (STIs), including HIV/AIDS. IR1's activities are intended to reinforce community mobilization and information, education, communication (IEC) and behavior change communication (BCC) activities (IR1.1), involve the private sector in health promotion (IR1.2), and target priority biodiversity conservation areas (IR1.3).

Reinforce community mobilization and IEC/BCC (IR1.1). An increase in demand for health services and products requires knowledge of healthy behaviors, positive attitudes toward health care, and willingness to use health services and products. Increasing community involvement in improving health at the local level has proven effective in changing behavior. Furthermore, IEC/BCC materials and campaigns are an important element for reaching communities with health messages and complementing community mobilization efforts.

Involve the private sector in health promotion (IR1.2). The private sector, in all its forms, has an important role to play in health promotion. Nongovernmental organizations (NGOs) are instrumental in complementing the public sector's work, providing systems and structures to reach local communities efficiently and effectively. Private media also are a powerful means of reaching remote populations, widely accessible to households through radio broadcasts. Private businesses have an opportunity to contribute to prevention efforts within their own companies as well as the surrounding community.

Target priority biodiversity conservation areas (IR1.3). Exploring the nexus between Health, Population, and Environment (HPE) is a priority for USAID Madagascar; activities in Madagascar have demonstrated that improving health indicators among remote populations also reduces pressures that can lead to environmental degradation. Areas in the "forest corridor" are considered priority

biodiversity conservation areas and are the focus of the Santénet's HPE activities.

ACHIEVEMENTS 2005 – 2006

IMPROVING COMMUNITY MOBILIZATION AND IEC/BCC FOR SELECTED HEALTH PRODUCTS AND SERVICES (IR 1.1)

PROVIDE ASSISTANCE TO PARTNER NGOS IN IMPLEMENTING YEAR 1 KAOMININA MENDRIKA ACTIVITIES (ACTIVITY 1.1.1)

In July 2005, the first cycle of *Kaominina Mendrika (KM)* began in 80 rural communes and one urban commune (see activity 1.1.4). For many NGOs, this was their first experience with the methodology. As a result, the introductory step took longer than planned, with activities gaining real momentum after October 2005. Santénet's challenge for this reporting period was providing technical assistance to its 11 partner NGOs in implementing the 10-step process and closely monitoring all activities as well as the communes' progress in achieving their health objectives.

KM monitoring system. During Quarters 2 and 3 of the reporting period, Santénet established a monitoring system utilizing different monitoring tools and mechanisms. In doing this, Santénet set up a mentorship system. This entail the assignment of a Santénet or a Voahary Salama team member as an NGO "mentor", responsible for providing technical assistance in implementing KM activities and monitoring progress. As a result, Santénet and Voahary Salama visited all 81 communes at least once during the reporting period.

Santénet also developed a series of monitoring tools — usually in the form of tables — for the NGOs and the mentors to use when supervising their communes. These tools measure each commune's progress by tracking the activities of each player's involved in implementing the KM approach: the KM Committee (KoKoMe), the community-based health center (CBHC), the NGO, the community outreach workers, including community-based distribution agents (CBDA), their supervisors, and the community itself. Tools include a performance table that collects quantifiable information such as progress on established indicators. Qualitative information was collected through guided focus group discussion that captured beneficiaries' understanding of and attitudes towards the KM approach.

In order to facilitate interaction and exchanges between Santénet and its partner NGOs, the Santénet central and regional offices held quarterly meetings with the KM partner NGOs to share information and find solutions to implementation problems and issues. Santénet, with assistance from Training Resources Group (TRG), also held a midterm KM workshop in April 2006. More than 100 participants — the majority of whom are directly involved in field implementation of KM — shared experiences and lessons learned, and formulated practical recommendations and improvements for implementing the remainder of the current cycle and the technical framework of the KM approach for Cycle 2. For instance, participants suggested that an independent endorsement committee, comprised of district and regional-level technicians, be set up to review and confirm a commune's self-evaluation. For the next cycle they recommended leveraging existing commune structures to the greatest extent possible; for example involving the existing Commune Development Committee rather than creating the *KoKoMe*.

KM mass media program. To support and facilitate the NGOs' community activities, Santénet developed a mass media program designed to introduce and enhance the work of community outreach workers, increasing their credibility among the community and making awareness-raising activities easier and more effective. In December 2005, the project established terms of collaboration with 60 radio stations for airing the mass media kit (a compilation of spots and stories — see Activity 1.1.6 for more detail). Forty-nine KM communes are currently in the listening areas of these radio stations. For more information on this collaborative effort, please refer to Activity 1.2.2. Santénet also provided each of the 81 communes with four mass media kits, one kit for the

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LEFT: During the *Kaominina Mendrika* festival, the commune is awarded a commemorative plate in recognition of all the efforts undertaken to achieve the health objectives.

RIGHT: All the different players who participated actively in the implementation of *Kaominina Mendrika*, for instance community outreach workers, are also publicly recognized during the festival.

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mayor, one for the health center, and two for the support technicians (ST) and their community outreach workers, thus facilitating the development of a mass media program for every KM commune.

KM evaluations and certifications. Santénet closely assisted the NGOs in implementing the ninth (evaluation and validation) and tenth (certification and celebration) steps of *Kaominina Mendrika*. Santénet developed specific guidelines on how the communes should be evaluated, based on the midterm KM workshop's recommendations. Santénet organized eight different regional meetings to share the guidelines with the NGOs and get buy-in from the 27 District Health and Family Planning Services (DHFPS) where the KM approach is being implemented. Santénet required the DHFPS be involved in the evaluation process as the final authority to decide whether a commune should be named *Kaominina Mendrika*. As of September 30, 2006, 25 communes completed their evaluations and were awarded the *Kaominina Mendrika* title, with Santénet present at 19 of those 25 festivals.

Highlight from Santénet Toamasina

Most communes in Toamasina Region began implementing KM in October 2005. The approach has demonstrated great results and yielded strong community buy-in in the 34 communes where KM is being implemented in the Toamasina province. As of September 30, 2006, 12 of the 34 communes have been awarded the Kaominina Mendrika title. Among them, the communes of Tsivangiana, Ampasina Maningory Ambodiharana, Ranomafana have made tremendous efforts to improve mother and child health. The commune of Tsivangiana far exceeded its tetanus inoculations objective for pregnant women, from 67.6% to 76.1%, by achieving 96.3%. In the commune of Ampasina Maningory, 961 pregnant women came for at least one prenatal consultation versus 407 women before. In the commune of Ambodiharana, 75.9% of children under one year received a DPT3 shot, against 35.7% before. In the commune of Ranomafana, the commune was able to increase the number of regular FP users from 339 to 470, thus increasing the contraceptive coverage rate from 12.2% to 16.9%. Just a few months ago, these four communes were not certain that they would be able to reach their objectives as the CHBCs' doctors were transfered. However, after seeing how effective the KM approach was to improve health indicators at the commune level, the MOH/FP dispatched new doctors to those communes, thus demonstrating its support to the success of KM. The festival in Ampasina Maningory, located in the health district of Fenoarivo Atsinana, was especially a success. Eight mayors from neighboring communes where the KM approach is not being implemented

attended the festival. It was an opportunity for them to ask that the KM approach be rolled out to their communes as it was clear to them the benefits of the approach for the local population.

	NGO	Commune	Region	Province	Date KM title awarded
1	ADRA	Amboasary	Alaotra Mangoro	Toamasina	July 20, 2006
2	ADRA	Ampasimpotsy Gara	Alaotra Mangoro	Toamasina	July 26, 2006
3	MCDI	Bezaha	Atsimo Andrefana	Toliara	August 19, 2006
4	MCDI	Ambatry	Atsimo Andrefana	Toliara	August 26, 2006
5	MCDI	Belamoty	Atsimo Andrefana	Toliara	August 30, 2006
6	CARE	Tsivangiana	Atsinanana	Toamasina	August 31, 2006
7	CARE	Mahela	Atsinanana	Toamasina	September 2, 2006
8	CARE	Amboditavolo	Atsinanana	Toamasina	September 9, 2006
9	ADRA	Anosibe An'ala	Alaotra Mangoro	Toamasina	September 12, 2006
10	MCDI	Mahaboboka	Atsimo Andrefana	Toliara	September 15, 2006
11	ADRA	Anosibe Ifody	Alaotra Mangoro	Toamasina	September 19, 2006
12	ADRA	Vodiriana	Alaotra Mangoro	Toamasina	September 20, 2006
13	AINGA	Ambohimiera	Vatovavy Fitovinany	Fianarantsoa	September 21, 2006
14	CARE	Tsaravinany	Atsinanana	Toamasina	September 21, 2006
15	AINGA	Tsaratanana	Vatovavy Fitovinany	Fianarantsoa	September 23, 2006
16	CARE	Ampasina Maningory	Analanjirofo	Toamasina	September 23, 2006
17	CARE	Betsizaraina	Atsinanana	Toamasina	September 23, 2006
18	MCDI	Ankazomanga	Atsimo Andrefana	Toliara	September 23, 2006
19	MCDI	Maromiandra	Atsimo Andrefana	Toliara	September 25, 2006
20	MCDI	Vineta	Atsimo Andrefana	Toliara	September 26, 2006
21	MCDI	St Augustin	Atsimo Andrefana	Toliara	September 28, 2006
22	AINGA	Antaretra	Vatovavy Fitovinany	Fianarantsoa	September 29, 2006
23	CARE	Ambodiharana	Atsinanana	Toamasina	September 29, 2006
24	AINGA	Ranomafana	Vatovavy Fitovinany	Fianarantsoa	September 30, 2006
25	MCDI	Andranovory	Atsimo Andrefana	Toliara	September 30, 2006

DEVELOP AND TEST A NEW MODEL FOR IMPLEMENTING KM. (ACTIVITY 1.1.2)

The objectives of this activity were to review the Cycle 1 *Kaominina Mendrika* approach and its technical framework, as well as to develop an improved implementation model that is more streamlined and efficient in order to scale-up the approach to 300 communes nationwide.

KM operational research. In order to assess the effectiveness of the current KM model and identify possible improvements, Santénet collected qualitative information during Q2 and Q3. In February 2006, Santénet conducted a qualitative study on communes' acceptance of the KM approach in 12 KM communes where KM is implemented by six different partner NGOs. Santénet organized 24 focus groups with KoKoMe members, community outreach workers, and household members. Through the research, the teams gained insight into the local population's perception of the KM approach, their motivation to participate in KM activities, and the actual level of effort invested by the different actors. The research also served to assess the different IEC/BCC tools developed to support the approach's implementation. To complement the focus group research, In March 2006, Santénet sent a questionnaire to all 11 partner NGOs to collect their opinions, comments, and recommendations for the KM approach. These two activities identified topics for discussion and debate for the midterm KM workshop in April 2006. As mentioned in activity 1.1.1, participants shared experiences

and lessons learned on KM, and formulated practical recommendations for improving the technical framework of the KM approach and implementing the KM activities during the next cycle.

Improved KM approach and implementation model. During Q4 Santénet processed the information gathered in the operational research studies and further refined its KM approach and the KM implementation model. The results are an improved approach and a more cost efficient implementation model. These are accomplished by:

- Reducing the original 10-step approach to seven steps by combining certain steps
- Better incorporating commune structures and more effectively involving the MOH/FP's decentralized structures
- Adapting the approach to include the 100-day Rapid Results Initiative (RRI), an objective-based approach largely promoted by the Government of Madagascar
- Selecting new communes that are in close proximity to Cycle1 KM communes, thus allowing for cost-sharing
- Reducing by one-third the cost of the first year of implementation
- Requiring a mere 30 percent of the first year's implementation budget to implement a second year in Cycle 1 communes

Furthermore, Santénet learned that geographical concentration of communes within health districts is a key to scale-up and success by ensuring involvement of and support from DHFPS. As a result, Santénet developed the Champion District approach (*Distrika Mendrika* (DM)), which requires that all communes in the district implement the KM approach. In this model, some communes will be assisted by an NGO, while others will be directly assisted by the MOH/FP. The MOH/FP will use the KM approach and tools; however, the model for implementing KM directly with the MOH/FP is currently being defined.

Review of KM materials. Finally, during Q4, Santénet and its partner NGOs worked together with TRG to start reviewing the content of all the KM guides and the training curricula. Cycle 1 experience showed that the content of KM guides and training curricula was too technical for players at the commune level. A concerted effort was made to make the KM tools easier to understand and more durable. All the revised tools will be available in November 2006.

BEGIN IMPLEMENTING YEAR 2 KM ACTIVITIES (ACTIVITY 1.1.3)

In June 2006, Santénet initiated negotiations with partners for KM Cycle 2 activities. Partners for Cycle 2 include NGOs as well as MOH/FP, which will directly implement *Kaominina Mendrika*

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LEFT: Santénet conducted a qualitative study on communes' acceptance of the *Kaominina Mendrika* approach and organized focus groups with KoKoMe members, community outreach workers, and household members.

in several districts, or *Distrika Mendrika*, through its Regional Health and Family Planning Directorates (RHFPD) and District Health and Family Planning Services.

KM Cycle 2 grants and subcontracts. While NGOs were still implementing Cycle 1 activities, Santénet started the Cycle 2 negotiation process to finalize new subcontracts and grants by the completion of Cycle 1, thus ensuring continuity and allowing the NGOs to retain their KM staff. The first negotiations were with CARE, ADRA and MCDI, as the most rapid KM implementers in Cycle 1. Santénet also initiated discussions with two new partner NGOs, PENSER and LINKAJISY, and with different RHFPD and DHFPS regarding DM. In July 2006, Santénet renewed the CARE subcontract, allowing them to begin implementing KM in eight new communes in the Toamasina Province, while completing the certification process in the 10 Cycle 1 communes. Santénet also awarded two grants to PENSER, one to implement KM in 10 new communes, and the other to implement FP and KM activities in nine remote "Extra Mile" communes. Fifteen of the 19 communes implemented by PENSER are located in the DM of Fianarantsoa II. To launch this first DM, Santénet, PENSER and SALFA (who will be implementing KM Cycle 2 in eight communes) organized an official launch in Fianarantsoa in July 2006, with the Minister of Decentralization and Land Development, the Minister of Health and Family Planning, the Minister of Population and the Secretary General of the Ministry of Environment in attendance. As of September 30, 2006, Santénet has thus initiated the KM approach in a total of 108 communes. Remaining grants, subcontracts and terms of collaboration will be finalized with the remaining NGO partners, the RHFPD and DHFPS in October and November 2006 to bring the total to 300 communes.

CARE Cycle 2 KM Communes	*Region*	*Province*
1. Ambatoharanana	Analanjirofo	Toamasina
2. Soanierana Ivongo	Analanjirofo	Toamasina
3. Ampasimazava	Analanjirofo	Toamasina
4. Mahanoro	Atsinanana	Toamasina
5. Majankandriana	Atsinanana	Toamasina
6. Niherenana	Atsinanana	Toamasina
7. Sahamatevina	Atsinanana	Toamasina
8. Tanambao Mahatsara	Atsinanana	Toamasina

PENSER Cycle 2 KM Communes	*Region*	*Province*
1. Ambalamahasoa	Haute Mahatsiatra	Fianarantsoa
2. Andoharanomaintso	Haute Mahatsiatra	Fianarantsoa
3. Andrainjato Centre	Haute Mahatsiatra	Fianarantsoa
4. Andrainjato Est	Haute Mahatsiatra	Fianarantsoa
5. Andranomiditra (Extra Mile)	Haute Mahatsiatra	Fianarantsoa
6. Ankarinarivo	Haute Mahatsiatra	Fianarantsoa
7. Fandrandava (Extra Mile)	Haute Mahatsiatra	Fianarantsoa
8. Ialamarina (Extra Mile)	Haute Mahatsiatra	Fianarantsoa
9. Ihazoara Andraramila (Extra Mile)	Haute Mahatsiatra	Fianarantsoa
10. Ivoamba	Haute Mahatsiatra	Fianarantsoa
11. Mahasoabe	Haute Mahatsiatra	Fianarantsoa
12. Mahatsinjony	Haute Mahatsiatra	Fianarantsoa
13. Taindambo	Haute Mahatsiatra	Fianarantsoa
14. Vinanintelo (Extra Mile)	Haute Mahatsiatra	Fianarantsoa
15. Vohimarina	Haute Mahatsiatra	Fianarantsoa
16. Ambatofotsy	Haute Mahatsiatra	Fianarantsoa
17. Manampatrana	Haute Mahatsiatra	Fianarantsoa
18. Ankazovelo	Haute Mahatsiatra	Fianarantsoa
19. Midongy	Haute Mahatsiatra	Fianarantsoa

Pool of national KM experts. During this reporting period, Santénet established a pool of national KM experts to help scale up the KM approach. This pool is comprised of individuals who master the KM approach and tools and are skilled in training. During Q4, Santénet and TRG trained 25 people from the partner NGOs in adult learning and training while strengthening their knowledge of the KM approach and tools. Nine of these individuals qualified as KM Trainers of trainers, and 12 as KM Trainers.

Training Health Districts to implement Distrika Mendrika. In September 2006, the KM trainers of trainers trained staff from the DM's RHFPDs and DHFPSs to become KM trainers. They trained 26 representatives from the district and regional health offices. As with the KM partner NGOs, they will be responsible for implementing the KM approach and training the different players in their communes.

PILOT THE TANÀNA MENDRIKA (TM) APPROACH IN FORT DAUPHIN (ACTIVITY 1.1.4)

Santénet has been implementing the *Kaominina Mendrika* approach in 80 rural communes. Working with CARE southern Madagascar, Santénet has also been implementing the approach in one urban commune (Taolagnaro, most commonly known as Fort Dauphin), which has been named Champion Town or a *Tanàna Mendrika (TM)*. The TM approach follows the same ten steps as in the KM approach. During this reporting period, Santénet supported the first seven steps.

Santénet provided technical assistance to introduce of the TM approach (Step 1), which led to restructuring the Commune Development Committee (CDC) to better represent all the commune's players. The CDC is a commune-level discussion and coordination structure which breaks down into three subcommittees: the Social Development Subcommittee (SDC) which incorporated the TM Committee (TMC), the Economic Development Subcommittee (EDC), and the Environmental Development Subcommittee (EnDC). The new structure was modeled after the KoKoMe used in KM, so that the SDC and TMC are responsible for coordinating, supporting, monitoring and evaluating health and education activities in the town.

Santénet also supported the TMC in setting objectives and took part in meetings leading up to the launch and contract signing (step 2). The official launch was coupled with the World AIDS Day festivities in Taolagnaro.

In Step 3, Santénet trained five CARE staff as IEC/BCC trainers and supported the same training of CBDA Trainers by PSI. CARE's staff then trained 64 IEC/BCC outreach workers, 62 of which were also trained as CBDA. The outreach workers/CBDA represent 16 CBOs partnering with CARE to ensure awareness raising and sales of social marketing products (SMP) in 11 neighborhoods of Taolagnaro. CARE initiated the education campaign first in February 2006, with CBDAs working first as outreach workers. In September 2006, CBDAs began selling products like water disinfectant, oral contraceptives, and condoms once the community needs were identified. Within the TM, there is greater flexibility in CBDA management — some NGOs compensate their outreach workers while others volunteer. Generally, CBDAs in the TM manage their products as a group, unlike the CBDAs in the more remote communes. During this step, Santénet also trained CARE's staff in the use of monitoring tools.

Santénet conducted monitoring visits in the 11 neighborhoods using the tool it designed as part of its support to Steps 4 to 7. The visits allowed Santénet to observe the level of mastery of health topics, appropriateness of topics discussed, and good identification of problems by the outreach workers, as observed during interpersonal communications. The monitors found that the educators' skits were highly entertaining and follow the required steps. However, there is a need to reinforce techniques for group education and discussions.

Santénet has also observed that the TMC has taken ownership of the approach during the last two months, and are using the performance table for decision making and planning.

Furthermore individual members of the TMC have championed the immunization outreach activities.

According the Performance Table from August 2006 (Table1), the TM approach has made headway exceeding the objectives they set for themselves. The table below shows results for key health indicators tracked by both the public and private health centers in the town of Taolagnaro.

Table 1:August Performance Indicators for Taolognaro

Indicators	*Objective for end of cycle*	*Baseline number*	*Number as of August 06*	*Percentage Increase in number*	*Rate of increase in number*
Regular users of modern contraceptives	635	527	607	96%	115%
Number of women who have completed one prenatal care visit	1,762	1,737	2,337	133%	135%
Number of women who have completed two or more prenatal care visits	1,721	1,198	2,032	118%	170%
Number of women who have received 2 or more Tetanus Inoculations	770	389	967	126%	249%
Number of children who have received DPT3	1,440	669	1,078	75%	161%

Table 1 shows that only the indicator for immunizations remains unachieved. This is largely due to a statistical error: the population size for Taolognara used by the DHFPS was based on projections calculated using 1993 general census figures. This number seems to be higher than the number of target population counted by outreach workers in the neighborhoods of Taolagnaro. Nevertheless, during the outreach activities, it was found that community members were not well informed of immunization schedules. To address this communication issue, the TMC formalized outreach days during the fourth weeks of July, August, and September 2006 and produced radio spots to inform the local population. Education and awareness-raising activities were also targeted at heads of neighborhoods, who can in turn educate and influence their communities.

ASSIST IEC AND SOCIAL MOBILIZATION UNIT (IECSMU) IN MAKING THE HEALTH COMMUNICATION AND MOBILIZATION COMMITTEE (HCMC) FULLY OPERATIONAL (ACTIVITY 1.1.5)

General assemblies of the HCMC. During the past year, the IEC and Social Mobilization Unit (IECSM) organized two general assemblies of the Health Communication and Social Mobilization Committee (HCMC). The HCMC is a technical platform bringing together IEC managers from the MOH/FP's different departments and from the partner organizations. The first assembly was held in October 2005 and produced a set of recommendations to improve the HCMC's functioning:

1. Establish a subcommittee charged with organizing the HCMC' meetings, with representation from each MOH/FP department, Santénet, WHO, and UNICEF.
2. Organize regional trainings in IEC/BCC, targeting IEC/BCC managers.
3. Formalize the HCMC.

The second assembly in April 2006 produced the following recommendations:

1. Formalize the HCMC through a ministerial decree creating a Health Communication and Mobilization Committee at national and regional levels.
2. Deliver all materials validated by

the NHCMC to the IECSMC for inclusion in the IEC materials library.

Santénet supported the IECSMC in preparing a bill to be submitted to the Legal Affairs Unit of the MOH/FP in October 2006. The official decree institutionalizing the NHCMC as well as its regional levels should be published shortly afterwards.

Capacity building for the IEC/BCC managers. The IECSMC collaborated with WHO and Santénet to host training sessions on efficient health communication programs to build IEC managers' capacity to lead national and the regional HCMCs. In a first phase, a training of trainers on IEC/BCC was organized in October 2005 for IEC/BCC managers at the central level. The goal of this training was to help them master IEC/BCC techniques that are specific to health. The second phase, scheduled for October 2006, will then train the newly appointed regional IEC/BCC managers. IECSMC, WHO, and Santénet worked together to develop a training curriculum based on the first training.

Study tour to improve communication skills. The IECSMC appointed one of its technical experts to follow up with the CCMs. To support this new strategic role, Santénet funded a two-week study tour for one person on communication in Belgium. This person will be a key resource for training IEC/BCC regional technicians, sharing her new knowledge with her colleagues.

CONTRIBUTE TO THE HCMC'S ACTIVITIES (ACTIVITY 1.1.6)

During the reporting period, Santénet contributed actively to several of HCMC's activities, including a review of IEC materials, organization of social mobilization days, and the development of the IEC messages guide.

Technical review of IEC materials. Santénet participated in five meetings to validate IEC materials produced by the MOH/FP's partners. Topics included family planning, and specifically the intra-uterine device (IUD), safe motherhood, nutrition, and malaria, produced by units of the MOH/FP and organizations such as Population Services International (PSI), the Malagasy International Planned Parenthood Federation affiliate (FISA) the Lutheran's Church Health Department (SALFA) and Marie Stopes International (MSI). The number of IEC/BCC materials reviewed by the HCMC demonstrates the committee's value in providing technical feedback and in ensuring quality.

Organization of health social mobilization activities. Santénet also contributed to social mobilization activities as an active member of the HCMC including: providing technical and financial support to commemorate African Malaria Day (April 2006) and World Health Day (April 2006), to organize campaigns for Vitamin A supplementation (May 2006), and for communication strategy development for prevention and control of avian influenza (March 2006).

IEC Messages Guide. Santénet provided significant technical and financial support to the MOH/FP, led by the IECSMC, in organizing workshops to update the IEC Messages Guide. The IEC Messages Guide is a reference document that includes key IEC messages for the different health programs and is to be used by IEC/BCC managers. The current version dates back to 1997. Activities included:

- Development of a questionnaire to collect information on the IEC messages and materials currently being used by the different health programs
- A workshop to fill out the questionnaire
- Analysis of the questionnaires and development of key messages elements based on behavioral analysis and issues impeding behavioural change
- A workshop to discuss key messages elements

CONTRIBUTE TO THE DEVELOPMENT AND IMPLEMENTATION OF THE FP COMMUNICATION STRATEGY (ACTIVITY 1.1.7).

FP communication strategy. During the reporting period, Santénet provided support to the MOH/FP's Reproductive Health and Safe Motherhood Unit (RH/SMU) in preparing its FP communication strategy. The communication strategy will support the MOH/FP's goal of increasing the contraceptive prevalence rate from 18

SANTENET 2006

LEFT: Women appreciate the FP invitation cards because there is less stigma associated with going to the health center to inquire about family planning, and the card is an effective ice-breaker during the first encounter with the doctor.

percent in 2004 to 28 percent by 2009 per the national FP strategy ratified in December 2004. In Q2, Santénet assisted the RH/SMU to utilize the results of UNFPA-funded research on RH/FP to define the FP communication strategy's three main components: (1) increasing demand for FP products and services, (2) improving access to and quality of FP products, and (3) improving the policy and institutional framework for FP. To involve the regions in developing the strategy, RH/SMU organized six regional workshops; Santénet funded four of six and co-facilitated the Toamasina and Fianarantsoa workshops with the MOH/FP team. The regional workshops provided an opportunity to create buy-in for the proposed components and to define the key messages and the appropriate communication, and allowed for strategy adaptation to address regional needs and contexts. In Q3 and Q4, Santénet assisted RH/SMU in preparing the strategy's first draft that was distributed to all FP partners for feedback. It is scheduled that the strategy will be finalized and approved in October 2006.

While developing the communication strategy, RH/SMU, IECSMU and Santénet felt that it was important to start implementing FP promotion and awareness-raising activities. Therefore, RH/SMU, IECSMU and Santénet, with technical assistance from Health Communication Partnership (HCP), undertook several activities during Q3 and Q4.

FP media campaign. RH/SMU, IECSMU and Santénet/HCP launched an FP media campaign in USAID's four intervention provinces. An FP radio kit, drawn from existing materials, was developed and included spots and songs on FP as well as oral and injectable contraceptives. Additionally, to assist the MOH/FP in encouraging the use of IUDs, Santénet provided support in developing two radio spots on the IUD. Santénet then contracted 48 of its 60 partner radio stations to air the spots twice daily from March through July 2006, according to a specific media plan (refer also to activity 1.2.2 for the collaboration with radio stations). KM, as well as non-KM communes, in the four provinces of Antananarivo, Toamasina, Fianarantsoa, and Toliara were covered by these FP radio spots.

Pilot FP invitation cards campaign. In September 2006, RH/SMU, IECSMU and Santénet/HCP piloted a new approach for recruiting new FP users in six pilot communes over a six-week period. The approach utilizes word-of-mouth, peer education and the use of IEC materials to convince close relatives, friends, or relations of the benefits of FP. During a three-hour introductory session, local authorities — the mayor, traditional and religious leaders, head doctors of the community-based health centers — were educated about the current FP situation in Madagascar and the benefits of FP. Santénet/HCP developed a simple, well-illustrated brochure to convey information simply to those local authorities They were then asked to recruit new FP users among their close relatives, friends, or relations by giving out invitation cards that invite the holder to go to the nearest health center for

information on FP, and hopefully adopt a contraceptive method. The head doctors were also asked to give three invitation cards to every one of their current FP-using patients and ask them to talk to their social circle about FP and encourage them to go to the health center. Mid-term evaluations have demonstrated striking results: after only three weeks, the number of women and couples who have come to the health centers to either adopt a contraceptive method or get information on FP has significantly increased. For example, in the commune of Bejofo in the Vakinankaratra Region, preliminary data show that more than 120 women and couples came to get information on FP, and more than 20 new FP users were recorded in one health center, up from traditional averages of only five new FP users per month. Women interviewed explained that with the invitation cards, there was less stigma associated with going to the health centers and that the card was an effective ice-breaker during the first encounter with the doctor. The final evaluation is scheduled to occur in October 2006. If the results are conclusive and the approach has been adopted by all FP partners, the approach will be scaled up nationally.

FP information and advocacy day for private doctors. In September 2006, the RH/SMU and all the FP partners organized an information and advocacy day on FP for private doctors practicing in the region of Analamanga, and specifically in the capital city Antananarivo. Santénet worked with collaborators like UNFPA, WHO, and the World Bank to provide technical and financial support to this first-time event aimed at reinforcing collaboration between the private and the public sectors in FP, which is especially important as urban women tend to visit private medical offices for family planning. The objectives were to educate private doctors about the new national FP strategy, recent developments in FP products and services, and to obtain commitments to promote FP and recruit new users. Santénet specifically assisted in developing the advocacy documents and the technical handouts. More than 400 doctors attended and asked questions about the current FP situation in Madagascar and the national FP strategy, voiced their opinions about the current public-private partnership, and made suggestions for improvement. The success of this pilot event has resulted in plans to follow up on this event and organize similar events in other regions.

STUDY THE FEASIBILITY OF ESTABLISHING CHILD HEALTH WEEK IN MADAGASCAR (ACTIVITY 1.1.8)

During Q2, Santénet held a meeting with the MOH/FP to present a concept paper introducing a Child Health Week in Madagascar. The Ministry approved the initiative and, at the Senior Inter-Agency Coordination Committee's meeting in June 2006, officially announced that the Vitamin A and deworming campaigns usually held in April and October would be replaced by Child Health Weeks; the first to be celebrated the week of October 23, 2006. In addition, the Child Health Committee endorsed Santénet's proposal to expand Child Health Week to include a minimum health service package for mothers, introducing the landmark initiative of the first Mother and Child Health Week (MCHW) in Madagascar. The main objectives of MCHWs are to

(1) encourage all families with children under five, and women between age 15 and 49, specifically pregnant women, to go to the health centers to receive vitamin A supplementation, deworming medications, immunizations, prenatal care and FP services
(2) encourage families to participate in the next MCHW in April 2007. Ultimately, providing these services during fixed periods every year helps parents and caretakers become accustomed to seeking these services at least twice a year.

ASSIST MOH/FP IN ORGANIZING THE FIRST CHILD HEALTH WEEK (ACTIVITY 1.1.9)

A steering committee was established to coordinate all the preparatory activities for Madagascar's first MCHW, scheduled for the week of October 23, 2006 with the national launch to be held in Mahajanga. Three subcommittees were also created, including the Social Mobilization Subcommittee. During Q3 and Q4, Santénet's IR1 team participated actively in all of the Social Mobilization Subcommittee's activities including developing the MCHW logo and slogan,

HCP 2006

LEFT: Eighty scout troops have been certified as "*Ankoay* Troops" because they have completed all the individual and group activities designed to raise awareness about HIV/AIDS within and outside the troop.

an advocacy document, a guide for community-based outreach workers, posters, banners, and TV and radio spots. Santénet took leadership in developing and producing the advocacy document; UNICEF, PSI, WHO, UNFPA, NNO, and MCDI led efforts to develop other IEC materials. Because of the close collaboration between the MOH/FP and all the partners, all IEC materials were produced by the end of the reporting period. Santénet will continue to provide support to MOH/FP during the month of October, and will act as the logistical focal point for the launch in Mahajanga.

CONTRIBUTE TO ES/NACC'S ACTIVITY OF TRAINING 150 RADIO HOSTS (ACTIVITY 1.1.10)

Please refer to Activities Not Completed.

PROVIDE ASSISTANCE TO THE IMPLEMENTATION OF THE ANKOAY PROJECT, PHASE II (ACTIVITY 1.1.11).

The *Ankoay* initiative targets youth between the ages of 15-18 and educates them about HIV/AIDS, teaching them how to become community leaders in prevention. After its launch among 100 scout troops in April 2005, the project has entered a scale up phase — reaching more scout troops and other youth groups, including sportsmen, women, and high-school students (See activity 1.1.12).

Activities with the scout troops. As the first part of the scale up, seven proposals were developed and submitted to the Executive Secretariat of the National AIDS Control Committee (ES/NACC) to expand activities to 200 new scout troops. While awaiting the release of funds, Santénet and HCP expanded the pool of *Ankoay* scout trainers with a second series of training of trainers in April 2006. As a result, 30 new trainers of trainers were trained, and began training troops in other regions; 65 new scout troops or more than 2,000 scouts, have been trained since December 2005. With ES/NACC funding, an additional five troops were trained in the region of Sambava in early September 2006. As of September 30, 2006 a total of 165 scout troops have been directly involved in the implementation of the *Ankoay* Scout Approach.

After 10-12 months of activities, 48 percent (80/165) of troops have been certified as "*Ankoay* Troops". The certification ceremony (a public recognition event) occurs during a community mobilization festival organized by the troops that are going to be certified. There have been ten certification festivals that publicly recognize the troops' certification, held in Analamanga, Vakinakaratra, Analanjirofo, Atsinanana, Alaotra Mangoro, Haute Matsiatra, Menabe, Vatovavy Fitovinany, and Bongolava. In addition to being an opportunity for the troops to show their talents and educate their communities, the *Ankoay* festivals — which are attended by many local authorities — are an opportunity for youth to be tested for HIV. During these festivals, 299 young people were tested.

A landmark *Ankoay* activity is the collaboration with UNICEF to monitor and assess the first 100 *Ankoay* scout

troops. UNICEF allocated funds to train 32 central evaluators and 278 regional evaluators and to establish 21 local evaluation committees to assess the troops. These structures allow close monitoring of the troops' progress and for participatory evaluation of activities before troops certified and hold festivals.

Collaboration with PSI to implement the Ankoay activities. Santenet/HCP has also signed a Memorandum of Understanding (MOU) with PSI to assist in scale up. Signed in May 2006, the MOU sets forth that PSI will:

1. Provide financial support from the PSI/Global Fund to air five *Ankoay* spots during three months on five television channels (one national and four regional channels)
2. Refer young people educated by *Ankoay* counsellors to the Top Reseau centers (a private health care center)
3. Pilot the provision of social marketing products to certified troops.

Expanding the Ankoay approach to junior high schools. In 2006, the *Ankoay* program was extended to schools (mainly junior high schools), in an effort to reach youth that do not participate in scouting as well as urban youth. The Ny Menafify Association launched a pilot program for students with funding from the ES/NACC, adapting the model to fit a school setting as an extracurricular activity in four schools in urban Antananarivo. Activities completed in 45 days exceeded expectations. The success led to the launch of the "*Ankoay Collège*" program, under the leadership of the Ministry of Education, in five junior high schools in the educational administrative areas of Mahanoro, Mahajanga I, Anjozorobe, Ambatondrazaka, Toliara I, Ambanja, Antalaha, and Mananjary. The *Ankoay Collège* program is receiving financial support from the ES/NACC and technical support from Santénet/HCP; implementation is led by the HIV control unit at the Ministry of Education and the Ny Menafify association. Workshops were held with the technical teams of the HIV control unit and the Ny Menafify association to adapt the *Ankoay* Scout approach to the school setting.

Thirty trainers of trainers from the HIV control unit at the Ministry of Education were trained in June 2006. Throughout Q4, instructors from the eight educational administrative areas were trained for the *Ankoay Collège* program. The instructors will be in charge of training six pupils in each school, totalling 240 students trained. In all, 600 *Ankoay Collège* kits were distributed during the training activities.

To complement the work with the Ministry of Education, the U.S. Ambassador's Girls Scholarship Program will utilize the *Ankoay* Junior high model with their scholarship recipients in 141 schools. The training activities have already started with trainers from the HIV unit control at the Ministry of Education.

Participation to national and international events. Since December 2005, the *Ankoay* approach has been listed among the ES/NACC's best practices to be replicated and promoted, and has become a reference for STI/AIDS control among young people. ES/NACC recommended that the approach should be scaled up and reproduced among other youth groups. The *Ankoay* approach has been invited to several social and cultural events. In December 2005, young people involved in the approach were invited by the National Public and Community Health Institute to take part in outreach activities to commemorate World AIDS Day. In February 2006, the U.S. Embassy and the CISCO of urban Antananarivo organized an inter-school basketball tournament during which the *Ankoay* troops and others presented HIV education programs, reaching an audience of 5,000 young people. In March 2006, the *Ankoay* scouts had the opportunity to meet the UN Secretary General Kofi Annan during his visit in Madagascar, and presented an *Ankoay* kit to him. In August 2006, ES/NACC representatives attended the Toronto International HIV/AIDS Conference and presented a poster.

Red Card Campaign to fight HIV/AIDS. The *Ankoay* program has recently introduced the "Red Card" which serves as a tool to combat HIV/AIDS by empowering young girls (12 and older) to say "no" in risky situations and thus avoid sexual abuse or coercion. The ES/NACC, the MOH/FP, the Ministry of Youth, the Ministry of Education, USAID/Madagascar, HCP, Santénet, UNICEF, and PSI are all involved in the large-scale implementation of the initiative.

LEFT: The "Red Card" serves as a tool to combat HIV/AIDS by empowering young girls (12 and older) to say "no" in risky situations and thus avoid sexual abuse or coercion.

DDC 2006

RIGHT: Four "Red Card" TV spots were produced that will be aired during the three-month campaign to be launched in October 2006.

DDC 2006

Designed to be a low-cost tool, the campaign will include several activities that promote the Red Cards in an informal way among peers and increase the likelihood that girls will effectively use their cards.

Several activities were completed before the launch of the campaign planned for early October 2006. Four Red Card spots were produced and approved by technical experts from the ES/NACC and the local organization Digital Development Communications. Fifteen-thousand red cards with 10,000 explanatory cards were produced. The Red Card kit, which includes IEC/BCC materials (explanatory cards, red cards, spots, posters, etc.) that will be used during the campaign, was also approved by the ES/NACC. Thus, the three-month campaign is ready to launch in October 2006.

IMPLEMENT *ANKOAY* TARGETING FOR YOUNG ATHLETES (ACTIVITY 1.1.12)

Ankoay's expansion will also target young people in rural areas, especially athletes in Santénet's KMs, expanding the reach of the initiative to even more youth. In 2006, the approach was implemented in 18 KM and has reached on average eight football I clubs with 30 to 40 young people per commune.

Sponsoring by the Minister of Youth and Sports. The *Ankoay* Sports program is sponsored by the Minister of Youth and Sports and is implemented by the National Sports Academy. A project implementation document was developed by Santénet, followed by an advocacy visit to Ministry staff to secure their involvement in implementation. As a result, two *Ankoay* Sport project coordinators were appointed at the National Sports Academy, and one in the Ministry's cabinet to coordinate the Ministry's involvement in the program.

Development of the Ankoay sport kit and training. An *Ankoay* Scout leader was recruited as a consultant to provide assistance in adapting the training model to the needs of sports clubs, result in the design and production of the *Ankoay* Sport kit. The revised draft was completed in July 2006 and approved by ES/NACC shortly afterwards. The training workshops for national and regional level Trainers of trainers were held, and in August and September 2006, they in turn trained the technicians.

Launching of the Ankoay Sports Program. Two clubs, AJESAIA, and EPNFC, participated in the launch of the *Ankoay* Sports program in July 2006. The launch day was marked by a football match between the two teams and community mobilization for HIV/AIDS prevention, reaching an audience of approximately 1,000. After the game, the players

presented HIV prevention messages to their supporters while a mobile VCT center tested 66 youth. The success of this event exhibits the approach's potential for mobilizing communities and encouraging young people to learn their HIV status and practice healthy behavior to fight HIV/AIDS.

A series of training activities for coaches and KM supervisors from partner NGOs in 18 KMs were organized in the provinces of Fianarantsoa, Toliara, and Toamasina, training 84 sport coaches in *Ankoay* methods. The coaches will train eight clubs of approximately 30 players per commune and will monitor and assess the teams. Furthermore, they will organize intra- and inter-commune *Ankoay*.

Two clubs serving as Ankoay Sport Ambassadors. Internationally known football teams, AJESAIA and EPNFC, participated in the launch and have accepted to acts as *Ankoay*'s Ambassador Teams. Each has received a second series of training for their players and will continue to present *Ankoay* messages after their matches. The teams, the National Sports Academy, and Santénet/HCP are drawing up an agreement outlining the Ambassador teams' responsibilities.

INCREASING PRIVATE SECTOR INVOLVEMENT IN PROMOTING HEALTH SERVICES AND PRODUCTS (IR 1.2)

STRENGTHEN IEC/BCC CAPACITIES OF KM PARTNER NGOS' COMMUNITY-BASED DISTRIBUTION AGENTS (ACTIVITY 1.2.1).

As part of the KM approach, Santénet supports social marketing product sales in rural areas by producing and distributing communication materials and the social marketing start-up kits to 1,800 CBDAs. Santénet also reprinted promotional and IEC materials used by PSI's retailers and will provide additional support to CBDA, who are already using Santénet's Child Survival and Reproductive Health booklets.

In Q1, with the support of the Community Animation Directorate at the Ministry of Telecommunications, Post, and Communication, Santénet organized nine advocacy days to discuss a potential collaboration with local radio stations. Santénet proposed "training-for-airing" to 65 radio stations: Santénet would train them in radio production in exchange for a commitment from each to air ten KM spots per day, and two skits and one tale per month for free. Santénet then developed training curricula for radio production techniques that addressed the development of spots, feature films, magazines, interviews, and reporting. In mid-December, Santénet organized five three-day training workshops. These workshops were attended by two representatives from each of the 60 radio stations (the breakdown of participants is: 16 in Toamasina, 6 in Antananarivo, 20 in Fianarantsoa, and 18 in Toliara.)

Soon after the training, the 60 radio stations started airing materials related to the KM initiative, demonstrating the benefit of the collaboration. The project estimates the value of the free airing of spots to be worth $140,000. The data available show that more than 600 communes are in the listening area of the partner radio stations, including 49 KM in Santénet's four intervention provinces, expanding the reach of KM messages.

Highlight from Santénet Toliara

In Toliara, eight local radio stations agreed to collaborate with Santénet with "training-for-airing". One of these is Radio Ragnalahy, a local radio station which covers 17 communes around the town Sakaraha, in the region of Atsimo Andrefana, province of Toliara. In addition to airing the KM spots, skits, children stories, and songs, Radio Ragnalahy decided to dedicate the two health talk shows it regularly airs twice a week to Kaominina Mendrika. In order to collect information and stories for the show, they visited several times the KM communes of Mahaboboka and Vineta and interviewed local players about their KM activities. During the festival of Mahaboboka on September 15, 2006, Radio Ragnalahy received special recognition from the commune for its important contribution in airing health messages and keeping the audience informed of progress towards set objectives. Radio Ragnalahy can be certain that it contributed to the improvement of mothers and children of Mahaboboka: the

contraceptive coverage rate from a mere 1.2% to 6%; 96% of pregnant women went to the CHBC for at least one prenatal consultation, when only 12% previously; all children under one year were immunized against DTPHepB3, when only 11.4% was immunized prior to the implementation of KM. Finally, several mayors from neighboring communes who have been aware of KM activities through Radio Ragnalahy attended the festival and asked that the KM approach be initiated in their communes

CONTRIBUTE TO THE IEC/BCC COMPONENT OF THE WORKPLACE INITIATIVES (ACTIVITY 1.2.3)

This activity was intended to target private companies and businesses located in the KMs. However, after some unfruitful discussions with company managers, Santénet turned its efforts to target the informal sector. In July/August 2006 Santénet, in collaboration with PSI, the MCH clinic of Tsaralalana and the BHC of Isotry, trained 70 hairdressers from the poor neighborhoods of Antananarivo in infection prevention and HIV education. To monitor hairdressers Santénet developed a monitoring tool in collaboration with the heads of the CBHC II in Tsaralalana and Isotry Central. The tool is used by the trainers in the two CBHCs to monitor the hairdressers they trained and their activities. This monitoring revealed that trained hairdressers practice interpersonal communication on HIV/AIDS prevention with about 10 clients per day on average. According to their reports, 100 percent of the hairdressers use a single-use blade with their clients and 60 percent apply the different infection prevention steps on their instruments. Following the success of this pilot, an IEC/BCC kit is currently being developed to facilitate hairdressers interpersonal communication with the clients. A scale-up strategy is also being planned.

INCREASING DEMAND FOR FP AND HEALTH SERVICES AND PRODUCTS IN PRIORITY CONSERVATION AREAS (IR 1.3)

ASSIST ERI IN THE IMPLEMENTATION OF THE INTEGRATED HEALTH-ENVIRONMENT KM APPROACH (ACTIVITY 1.3.1)

Out of the 81 communes where the KM approach is being implemented, 27 are located in the forest corridor. Santénet and USAID's environment project, Eco-Regional Initiatives (ERI), work together in 11 of those 27 communes, six in the Fianarantsoa province and five in the province of Toamasina.

Two communes in Fianarantsoa were certified as health and environment KM communes in September 2006. The other communes are at the evaluation stage, anticipating certification in October 2006. Santénet provided technical support to ERI to implement the Environment KM activities in the 11 communes: development of the menu of environment indicators, the initiation of KM approach, and the sharing of the health KM tools. It also trained ERI's technicians on IEC/BCC for health topics. Rural development trainers provided education in FP and other health topics, and conducted activities related to the availability of safe drinking water in communes where Santénet and ERI work together, especially in those located in the Haute-Matsiatra and Vatovavy Fitovinany regions in Fianarantsoa.

As part of its support to the expanded KM approach integrating other technical areas of development (environment, economic growth, governance, and education), Santénet has led the development of a KM methodological guide based on the tools from Cycle 1. In addition, Santénet participates in the Commune Support Committee/CC Task Force (now called the Commune Support Task Force), which supports communes in managing their own development through the development of strategies and supportive supervision

Highlight from Santénet Fianarantsoa

In collaboration with ERI and Voahary Salama member NGOs (MICET, AINGA, and Ny Tanintsika), SN Fianarantsoa supported integrated KM activities in six communes bordering or located within the forest corridor in Fianarantsoa region. Indicators developed for environmental protection and economic development include

- *Number and membership levels in rural farmers' Koloharena*

associations, links between existing neighboring associations
- *implementation of the farmer-to-farmer approach*
- *access to potable water and improved hygiene*
- *quality of food for pregnant and breastfeeding women and children, especially in terms of calories, protein and vitamin A;*
- *level of dissemination of population-health-environment messages and alternatives to deforestation and burning.*

Members of the Fianarantsoa Eco-Regional Alliance continue to collaborate with ERI and SN to promote population-health-environment messages in their intervention zones along the forest corridor, a priority biodiversity conservation area.

Highlight from SantéNet Toamasina
Santénet Taomasina has also worked with ERI to implement the health and environment components of KM in five communes. Communities are building awareness for integrating health and environmental activities to solve hygiene and sanitation problems. The communities have demonstrated a clear understanding of the effectiveness of multisectoral development, adopting different techniques to benefit both health and the environment. These include: intensive/improved rice farming, kitchen gardens, reforestation, composting and building garbage pits.

During the Eco-Regional Alliance meeting in Toamasina in September 2006, communities further demonstrated their determination to implement the KM approach. Participants advocated for the KM approach, praising its effectiveness in the different sector, as well as a tool for good local governance and local capacity building. .

Highlight from SantéNet Taolagnaro
During the launch of KM, all of ASOS communes included environmental and good governance objectives through reforestation and birth registration. As part of the reforestation activities, the communes had planned to collaborate with the Taolagnaro regional office of the Water and Forest Department and the NGO Jariala. Unfortunately, the number of plants provided by the Water and Forest Department did not cover the targeted 20 hectars per commune. While most communes did not achieve their objectives in this area, as a result, the Mayor of Ankaramena worked to find other sources of tree plants, allowing his commune to achieve its surpass the objective of 20 hectars.

ACTIVITIES NOT COMPLETED IN 2005 – 2006

CONTRIBUTE TO ES/NACC'S ACTIVITY OF TRAINING 150 RADIO HOSTS (ACTIVITY 1.1.10)

In the 2005 work plan, Santénet was to carry out this activity after a local organization working with the ES/NACC to train radio technicians, Concorde submitted a monitoring and evaluation report on the training it provided to radio stations, and was to use the trained radio stations to produce and air IEC/BCC materials in the KMs. The report has not yet been completed, therefore Santénet decided to replace the activity with Activity 1.2.2.

RESULTS AND IMPACTS IN 2005 – 2006

Significant improvements of health indicators in the KM communes. Santénet has demonstrated that, when given a clear methodology, appropriate tools, and technical assistance, communes are capable of making notable progress to improve key health indicators in a short time period (12-15 months). Indicators include the immunization rates, increase of regular/new family planning (FP) users, and number prenatal consultations. By working in 81 communes, Santénet and its partner NGOs are reaching more than 1,160,000 men, women and children. As of September 30, 2006, the MOH/FP and Santénet have awarded the *Kaominina Mendrika* title to 25 of the 81 communes that participated in Cycle 1 and reached their health objectives. Annex 1 presents the results achieved in each of the 25 communes. The table below presents the aggregate results achieved for contraceptive coverage rate, prenatal consultations, tetanus inoculations and DTPHepB3 in the 25 communes. Although certain national objectives were not reached, the numbers in Table 2 clearly show the

significant improvement in those key health indicators in the 25 communes

Table 2: Objectives
Total population for the 25 certified communes: 348,253
Number of women of reproductive age (23%): 80,098
Number of expected pregnancies (4.5%): 15,671
Number of children 0 – 11 months (4%): 13,930

	Beginning of Cycle 1	*End of Cycle 1*	*MOH/FP national objective*
Contraceptive coverage rate	5.00%	11.00%	2.00% increase per year in order to reach 28.00% by 2009
First prenatal consultations	34.00%	73.31%	80% of pregnant women come for a first prenatal visit
Tetanus inoculations for pregnant women	22.00%	117.63%	80% of pregnant women are vaccinated against tetanus
DTPHepB3	38.00%	88.41%	80% of children under one year are vaccinated against DPT3

The remaining 56 communes will be evaluated in October 2006. Communities are now more aware and informed about the local health situation, and are more empowered to make improvements. All 25 certified communes intend to sustain their efforts by implementing KM for a second year.

Reinforced public-private partnerships for the development of communes. District Health and Family Planning Services that were involved in the assessment and certification phases of KM stand ready to participate in the second cycle. Many have strengthened their relationships with the implementing NGOs and have requested not only to participate in the evaluation step, but also in the establishment of objectives as well as monitoring. This strategic partnership will be very important to the DM approach as the NGOs and the DHFPSs will have to work closely together to make sure that at least 90 percent of the communes in the *Distrika Mendrika* receive the *Kaominina Mendrika* title.

Significant headway to scaling up the KM approach and making it sustainable. Cycle 1 NGO partners have experienced the advantages of the approach for improving health indicators at the commune level. They have decided to adopt the KM approach as a platform on which to build their other interventions, and as a result, there will be more opportunities for cost-sharing to implement KM in new communes. For almost the same total monetary amount of grants and subcontracts for Cycle 1, Santénet will be able to scale up implementation from 81 to 300 communes, meeting the project's target a year in advance.

The positive results and the effective social mobilization brought by the *Kaominina Mendrika* approach have also sparked interest within the Government of Madagascar. The Ministries of Health and Family Planning, Environment, Education, and Decentralization and Land Development all view the approach as a potential tool for commune-level development and are interested in developing and implementing a multisectoral KM approach using the same technical framework and tools as were developed for the health sector.

The creation of a pool of national KM experts is an important tool to help scale up the KM approach. The nine KM Trainers of trainers and 12 KM Trainers will be able to improve the quality of KM training within their own organization and in the communes where they intervene, and provide training for other NGOs, institutions, donors, and ministries interested in implementing the KM approach. New NGOs and donors have expressed their interest in the approach, including Linkajisy, National Nutrition Office, ZETRA, WWF, and the World Bank.

Increased visibility of IEC/MSU and increased importance of communication (IEC and social mobilization) at MOH/FP. The number of IEC/BCC materials reviewed by the HCMC demonstrates

the committee's value in providing technical feedback and in ensuring that IEC/BCC materials are of the highest quality. Several partners have also begun systematically pre-testing their materials, which is strongly recommended by the HCMC as an essential step in developing IEC/BCC tools. The increasing importance of the HCMC has given increased visibility of IECMSU within MOH/FP as well as an increased leadership role in IEC and social mobilization among the health partners. This has obliged the IECMSU to evaluate the roles, responsibilities and qualifications of the IEC personnel in the MOH/FP to design, implement, and monitor communication strategies and activities. As a result, IECMSU is training all central and regional IEC personnel.

Scaling up of Ankoay as the main strategy for HIV/AIDS prevention among young people As a result of the Santénet's and HCP's efforts, the *Ankoay* approach has become the ES/NACC's main strategy for involving youth in HIV/AIDS prevention. Between October 2005 and September 2006, 80 of the 166 scout troops completed all activities and graduated as *Ankoay* Scout Troops. The 80 scout troops represent approximately 2,400 boy and girl scouts. As part of the *Ankoay* model, each scout is required to reach out to 10 non-scout youth, bring the total reached by the first year of *Ankoay* to 24,000. In addition, 229 young people accessed VCT services for HIV/AIDS during the festivals. HCP and Santénet adapted the approach for implementation in junior high schools (*Ankoay Schools*) and sports clubs (*Ankoay Sports*) in order to reach a larger number of young people. The *Ankoay Schools* approach has been initiated in 188 junior high schools and approximately 5,500 students are directly involved. The *Ankoay Sports* approach has been initiated in 18 KM communes, and 144 soccer teams, representing about 3,100 players, are directly involved. The ES/NACC presented the approach at the International AIDS Conference in Toronto, Canada, in August 2006, demonstrating their ownership of the approach.

Greater health promotion around the forest corridor. Twenty-seven of the 81 KM communes are located around the forest corridor (see map). All of these communes are working to improve their health indicators, including family planning, which is vital to reducing pressure on the forests and its biodiversity. The fact that these communes implemented the KM approach to achieve health targets has triggered their interest in applying the approach to achieve environmental targets as well. Eleven of the 27 communes are already working with ERI to implement the integrated health-environment KM approach, and the remaining 16 have expressed their desire to participate in the next cycle.

CHAPTER FOUR: INTERMEDIATE RESULT 2 (IR 2)

INCREASING AVAILABILITY OF SELECTED HEALTH SERVICES AND PRODUCTS

INTRODUCTION TO THE INTERMEDIATE RESULT

Whereas IR 1's focus is to increase demand for services and select health products, the activities of IR 2 strive to increase access to these services and products. Santénet provides technical support to the MOH/FP and its partners to ensure better availability and access to services and health products that encourage family planning, improve child health, combat malaria, and prevent STIs, including HIV/AIDS. Specifically, the activities of IR 2 will improve the logistics systems for the public sector (IR 2.1), support the development of a private sector distribution network for socially marketed products (IR 2.2), increase access to priority services for remote populations (IR 2.3), improve the nutritional value of agricultural products (IR 2.4), and improve water management for agriculture and households (IR 2.5).

Improve the logistics system for the public sector (IR 2.1). SALAMA, the central drug purchasing agency, procures generic essential drugs and delivers them to the district level which in turn assumes the responsibility of distributing drugs to the community based health centers. However, weaknesses in commodity management and distribution systems represent serious impediments to ensuring consistent availability of health products. All levels lack reliable forecasting and stock management systems, resulting in repeated stock-outs. The cold chain, which ensures the delivery of vaccines and other drugs that require certain storage conditions, also periodically experiences problems due to lack of spare parts and fuel shortages for equipment. An inadequate cost-recovery system endangers the sustainability of the public health systems' ability to deliver quality health services and products. It is thus urgent to address deficiencies in the commodity management and distribution system.

Expand the wholesale and retail network for socially marketed products (IR 2.2). The private sector in Madagascar has played an important role in ensuring the availability of health products, especially social marketing products like condoms, bed nets, and safe water products, and seeing that product availability corresponds to increased demand.

However, the role of the private sector should be expanded to relieve the burden on the public sector and provide greater access and choice to the Malagasy people.

Increase access to priority services for remote populations (IR 2.3). Availability of health services and products is also a concern, particularly for the most underserved populations in remote, disaster prone, and priority conservation areas. While more than 80 percent of the Malagasy population lives in rural areas, 65 percent are estimated to live within a five-kilometer radius from the nearest health facility. Despite this level of coverage, numerous barriers to health care remain: geographic access is impeded due to poor road conditions, especially during the rainy seasons; endemic poverty creates economic barriers such as the inability to pay for needed curative care services; service provision is often inconvenient to rural, farm-working populations who find themselves facing long wait times for services.

Improve the nutritional value of agricultural products (IR 2.4). Malnutrition is a serious health issue in Madagascar: over 50 percent of children under age five suffer from malnutrition, resulting in stunted growth rates and increased vulnerability to disease. Families, especially in rural areas, have limited income and their diets often lack nutritional balance. In order to reduce malnutrition, their knowledge and attitudes regarding nutrition must be improved. This implies that high nutritional value foods must also be made available to households and local communities. High nutritional value foods must also be made available to households to meet newly-created demand.

Improve water management for agriculture and households (IR 2.5). Contaminated water is an important cause of water-borne diseases, including diarrhea, a major cause of child mortality. In Madagascar, access to safe water (through household connection or public standpipe) is estimated at about 65 percent in urban areas, and only between 10 to 20 percent in rural areas. Although several donors and NGOs are working to provide long-term solutions to safe water access, water security is a critical and immediate household, livelihood and health issue. PSI Madagascar is currently marketing a safe water system locally known as "Sûr'Eau" which addresses the issues of contaminated source water and unsafe water storage. Efforts should be undertaken to ensure better access to this socially marketed product.

ACHIEVEMENTS 2005 – 2006

IMPROVING THE LOGISTICS SYSTEM FOR THE PUBLIC SECTOR (IR 2.1)

SUPPORT THE LOGISTIC SYSTEM FOR CONTRACEPTIVE PRODUCTS BY IMPROVING INTEGRATION WITH GENERIC ESSENTIAL DRUGS (ACTIVITY 2.1.1)

To ensure the sustainability of the supply of public sector contraceptive commodities, the MOH/FP began integrating contraceptive commodities into the Generic Essential Drugs (GED) supply chain during Q4 of 2006. SALAMA, the government's central pharmaceutical purchasing department, ensures the distribution of contraceptive commodities at the district level following a quarterly supply plan. Santénet provided technical support to the MOH/FP to reinforce the District Health Services' ability to manage the supply chain through monitoring of the District Health Services' quarterly orders. At the same time, a monthly report on supply management has been developed by Santénet in collaboration with the RH/SMU.

The analysis of the FP logistics survey results in November 2005 revealed that while stocks were inadequate at the regional and district levels, there were sufficient supplies available at the central level. Therefore, Santénet recommended adjusting the maximum stock levels at regional and district pharmacies. Furthermore, the pilot monitoring system the SALAMA's District Health Services, showed problems related to distributing the ordered contraceptives. Thus, beginning in April 2006, new parameters were established for maximum stocking requests, converting the distribution

system to a "pull" rather than a "push" system. Immediately following these recommendations, each order from the DHFPS was increased to match 11 months' worth of consumption. In addition, Santénet collaborated with the RH/SMU team to design and put in place a computerized tool for contraceptive commodities management and data analysis. This tool, installed in Q2 of 2006, creates a dynamic database at the DHFPS level and increases the national FP program's ability to respond immediately to crisis and correct any problems.

Throughout the year, Santénet provided technical and financial support to SALAMA and the district level pharmacy wearhouse, PhaGDis, essential players in the GED supply chain. To identify problems in the supply chain and logistics management systems, and to define strategies for solving problems encountered, Santénet assisted in preparing monthly reviews of contraceptive supplies and in organizing the annual RH/FP coordination meetings. In addition, Santénet has monitored the implementation of recommendations that came out of the FP partners meetings.

Central level monitoring of orders and district-level deliveries allowed each player to give feedback during the meetings. To turn recommendations into actions, regular quarterly meetings were instituted between the RH/SMU, Santénet, and SALAMA, which provided an opportunity to review quarterly results and take appropriate action to ensure the availability of products at the PhaGDis level.

This year Santénet technically supported the RH/SMU to analyze FP logistics data, specifically contraceptive commodities consumption by regional, district, and product. This helped to calculate the Couple Years of Protection (CYP) and the Contraceptive Coverage Rate (CCR) from 2000 to 2005. It also allows for better central monitoring of contraceptives stock management (transfer of commodities to SALAMA's warehouse), analysis of changes, and support for the changes to the district and regional stock levels for development of new contraceptives management guidelines, management of contraceptive stock orders, financial management, and participation in the FP logistics committee. The data needed to estimate contraceptives needs are now available and have been forecasted through 2012.

SUPPORT THE MOH/FP IN THE PROCUREMENT OF CONTRACEPTIVE PRODUCTS (ACTIVITY 2.1.2)

Santénet is a member of the National Coordination Committee, which includes the MOH/FP (Family Health Directorate) and other partners working in FP. The coordination committee, called the FP Partners Committee, was established to ensure availability of reproductive health commodities, to develop and determine strategies for repositioning FP, and to reinforce an efficient coordination mechanism to implement the new strategy. The following activities fall under this goal:

- Organization of a national RH/FP coordination workshop
- Establishment of the FP partners' committee: writing terms of reference
- Presentation of strategies for advocating with the MOH/FP
- Development of a contraceptives procurement plan for years 2006, 2007, and 2008
- Acquisition of adequate funding for the contraceptives procurement plan for 2006-2008
- FP partner approval of the funding of the procurement plan
- Finalization of a guaranteed and secure funding scheme

Given the increased of FP observed during the last year, subsequent funding of RH programs including FP will need to grow steadily. Santénet supports the RH/SMU in the forecasting activities twice a year, to facilitate the increase in funding. Procurement plans for 2006, 2007, and 2008 were developed and approved by partners, securing adequate funds for the next two years. Plans for financing 2008 needs will be finalized in Q4 of 2006.

Partner financial participation in procurement of contraceptives has remained at the same level for many years, and will become inadequate given the country's ever-increasing needs. The national FP program recognized the need to develop a contraceptive security strategy and, with Santénet's technical and financial support, organized an

assessment workshop to review the contraceptive security situation vis-à-vis supply chains, institutional frameworks, access to FP products and services, use of contraceptives, and resources and funding. The result of the workshop was a strategic framework for contraceptive security for 2007-2011 based on the Madagascar Action Plan (MAP). The contraceptive security plan complements the new FP strategy by ensuring resource availability. This action plan marked the first time that the GOM used its own funds to purchase contraceptives, including $100,000 in the 2006 budget to procure injectable contraceptives for 2007. Santénet's technical support contributed to this landmark success that will positively impact the sustainability of FP actions and the contraceptive prevalence rate in Madagascar.

Strengthening the LTPM supply: revitalizing IUD. As part of repositioning the FP strategy and expanding the range of available contraceptive methods, long-term permanent methods (LTPM) like the IUD, can meet couples' desire to reduce family size and contribute to increasing contraceptive prevalence.

The RH/SMU used a multisectoral approach to revitalize the use of the IUD and to make it available to users through all FP service provision channels, integrating the public sector, NGOs, and the private sector. Santénet supported the organization of several planning and training workshops for developing a multisectoral action plan. The workshops:

- Analyzed the availability of IUD services (sites providing services, staff trained in IUD insertion),
- Planned for the revitalization of the use of the IUD
- Updated the clinical reference manual, the training curriculum, and the practicum workbook to reflect WHO guidelines
- Tested and finalized the IUD curricula
- Developed regional cascading training plan
- Developed the trainers' workbook and the participants' workbook for IUD training
- Produced IUD reference documents

UNFPA and WHO provided financial support that used the IUD curricula to train 42 service providers in four regions and 22 DHFPS.

Publishing the quarterly FP newsletter for service providers (Newsletter EZAKA). Santénet supported the MOH/FP Family Health Directorate and RH/SMU to build on achievements of the national FP program and share and exchange related information by publishing a quarterly technical newsletter on FP. The newsletter EZAKA aims to disseminate experiences, innovations, new developments in FP as well as improve the value of results by sharing them. As such, the newsletter's target audience includes health professionals, decision makers (local and national authorities), and partners, with a circulation of about 1,500. The newsletters were distributed to FP service provision centers as well as to SM/FP managers at the DHFPS and the regional directorates.

In this way, Santénet has been providing technical, content, editorial, and distribution support to the production of three issues, which focused on: (i) contraceptive commodities supply chain, (ii) LPTM revitalization and introduction, specifically IUD and Implanon®, and (iii) application of the Rapid Result Initiative to FP/SM. Santénet helped to establish an editing committee and publish the newsletter for FP service providers in the public and private sectors.

FP logistics survey. In collaboration with the MOH/FP, Santénet carried out a survey in 16 DHFPS, covering 96 FP sites, to assess the performance of FP public sector service delivery points in contraceptive commodities supply chain management. It measured 2006 performance, and compared it to the preceding year in the areas of product availability; maintaining the supply schedule; and tracking consumption to adjust reorders. Survey results will be used by the FP committee and partners to make decisions on FP logistics. A training of trainers (TOT) for survey supervisors was conducted in August and September 2006, training them to data collection, data analysis, and result dissemination.

RRI applied to FP/SM- To apply the Rapid Results Initiative (RRI) to FP and SM, Santénet provided technical and financial support for critical start-up activities. The rapid results initiative creates objectives on a certain topic with the goal of

attaining them within 100 days Santenet funded the initiative in six regions (Haute-Matsiatra (Ambohimahasoa), Vatovavy Fitovinany (Manakara), Atsinanana (Vatomandry), Ihorombe (Ihosy), Atsimo Atsinanana (Farafangana) and Anosy (Taolagnaro)) to conduct advocacy and sensitization, TOT, planning, internal TOT, and launch of the RRI/FP. Santénet's support allowed the regions to carry out FP/SM promotion. In total, all 22 regions established RRI/FP in 44 DHFPS, creating 106 FP sites.

Seventy-one FP sites reported results over the 100-day period of the RRI, charting their progress over time:

- After 50 days, 13 reported results, only one achieved more than its objectives.
- After 75 days, 32 sent intermediate reports: eighteen (56.3 percent) exceeded their objectives and fourteen (43.7 percent) had not achieved them.
- After 100 days, 24 sites reported results. Nineteen (79.2 percent) exceeded their objectives; 5 (20 percent) did not achieve them.

Strengthening the FP program: support to the RH/SMU. To further strengthen the MOH/FP team, Santénet provided technical support to introduce Implanon® and the SDM, to develop a research protocol for assessment of Implanon®, and to prepare a feasibility study for community-based distribution of injectable contraceptives.

Capacity building in contraceptives management for managers at the district and regional levels.. The availability of contraceptives is a critical element for women and couples who have chosen modern FP. This is complicated by the dearth of formally trained service providers. Per-service formal training is critical, but not always feasible, yet service providers must be able to provide quality FP services when beginning to care for patients. To address this need, Santénet collaborated with the MOH/FP to develop job aids — simple visual materials to help provide essential information, securing contraceptives supply, and ensure quality management. The job aids include posters for consultation rooms, for the DHFPS RH/FP managers' offices, for the PhaGDis depots. They cover the following topics:

- Contraceptive commodities: receiving and managing stocks
- Ordering: information needed for writing a purchase order
- Managing income: sharing income and use in the FP site

Other job aids address basic management activities, including a reference manual for logistics management in a new FP site.

Technical support for the implementation of community-based Depo Provera®. Santénet provided support to the MOH/FP in establishing a Steering Committee to conduct a feasibility study on community-based injectables (Depo Provera). Specifically, the project assisted the committee in preparing the study in two selected pilot sites (Moramanga and Anosy – Taolagnaro).

Technical support for the Religious Leaders Platform. The platform of faith-based organizations grouping nine religious entities received funding from the Flexible Fund for an FP promotion project in Madagascar. Santénet helped write the concept paper and develop the proposal, which established the implementation plan for three years of activities, and assisted in building the district and regional-level managers' capacities to implement activities in accordance with the donor's requirements. Achievements and results are further described under Activity 4.4.1.

SUPPORT THE ESTABLISHMENT OF NEW FP SITES IN HEALTH CENTERS (ACTIVITY 2.1.3)

The objective of the national program is to achieve universal coverage by 2007. Santénet provides timely technical support the activity upon the RH/SMU unit's requests. To meet the objective of the national program, Santenet is helping plan and monitor the implementation of the FP site extension strategy. Since the implementation of the strategy, coverage has increased from 70% in 2004, to 80% in 2005 and 90% in 2006, moving steadily to the goal of 100%. Between October 2005 and July 1006, 104 new FP sites became operational.

SUPPORT TO THE IMPLEMENTATION OF REACH

EVERY DISTRICT FOR EPI (ACTIVITY 2.1.4)

In December 2005, Santénet and the Inter-Agency Coordination Committee (IACC)helped to launch two new initiatives to reinforce the immunization program: (i) RRI was applied to DTPHépB3, under which objectives related to access and quality of the immunization program were set, and (ii) the reinforcement of the Reach Every District (RED) approach in poor performing areas through a peer approach. Under this initiative, staff from high-performance areas visit staff in low-performance areas for active support in order to increase the immunization coverage rate. Santénet played a key role in the success of the two initiatives by providing technical and financial support to the MOH/FP in introducing and implementing them in the regions of Atsinanana and Haute-Matsiatra.

As decided at the September 2005 IACC's meeting, Santénet contributed to developing the 100-day approach and the RED — introducing, supervising, and assessing the approaches in the Regional Health Directorates of Atsinanana and Haute-Matsiatra.

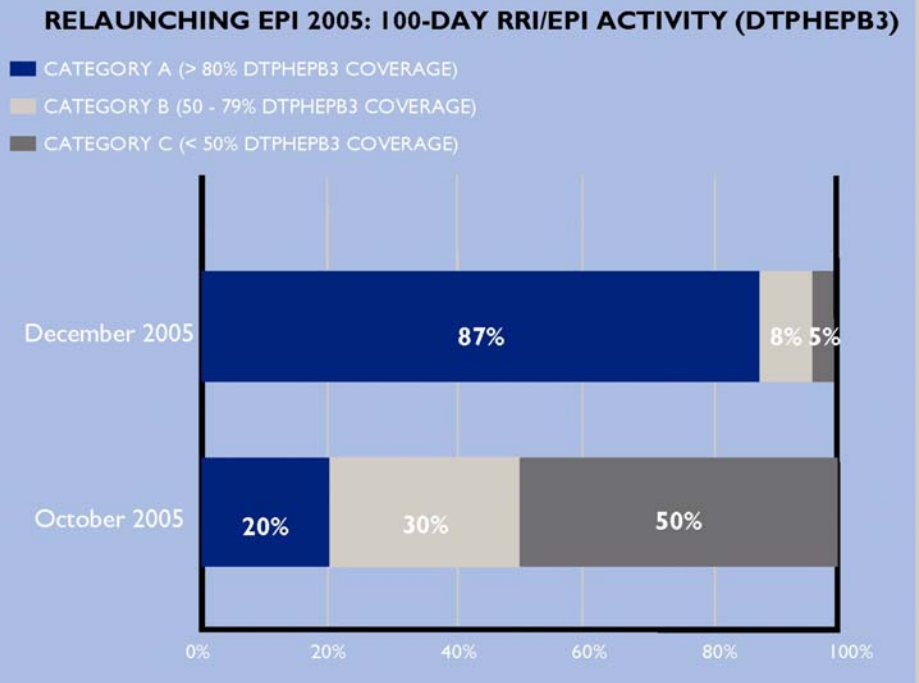
In order to achieve the national immunization coverage objective of at least 80 percent, Santénet supported the MOH/FP in implementing the 100-day approach to strengthen routine immunization. The project monitored the progress of activities related to the 100-day RED approach, organized a micro-planning workshop for RED and EPI revitalization (Ikalamavony, Ambohimahasoa, Ambalavao, and Fianarantsoa I & II), assessed the 100-day EPI revitalization, organized workshops to monitor the 100-day approach in the regions and to present the results of the RRI/EPI.

Santénet also supported routine EPI activities and improved immunization coverage in 111 health districts through regional and district level management training for health workers. As a result, 55 health workers were trained in Middle Level Management (MLM) for EPI, 18 people from the Haute-Matsiatra region were trained in Data Quality Control (DQD), and 133 people from eight regions were trained in the use of computerized management tools.

Santénet also participated in the technical subcommittees within the IACC, in training EPI managers in the regions, and in funding revitalization activities.

Revitalization EPI 2005 - 100-day activity (DTPHepB3):

Category	A (> 80%)	B (50 - 79%)	C (< 50 %)
Number of DHFPS at the beginning	22	33	56
Number of DHFPS at the end	97	9	5



ABOUT THE GRAPH: As shown in the the graph and the table, 24 DHFPS moved from Category B to Category A, and 51 from Category C to Category A over a three-month period, which means that more than 90 percent of the DHFPS have now a coverage rate for Diphteria, Tetanus, Pertussis and Hepatitis B of more than 80 percent.

External assessment of Data Quality Control. Since 2001, Madagascar has been one of the countries benefiting from the Global Alliance for Vaccines and Immunization's (GAVI) funding for routine EPI. Organization and monitoring of immunization activities are a very important part of the contract managed by the national IACC. As a technical partner, Santénet took part in preparatory meetings for the external evaluation, in data collection missions, and in the validation of the external assessment results.

The immunization unit is faced with the following problems:

- Poor data entry quality for the MAR
- Lack of clear guidelines
- Low management capacity of the staff at the DHS/RHD
- Difficulty in conducting outreach remote villages
- Lack of human resources (in general one service provider per BHC to provide all services)

The DQC audit:

- Assessed the administrative reporting system in Madagascar for quality, accuracy, timeliness, and completeness
- Audited reported DTPHepB3 immunizations among children under one year of age in 2005
- Estimated verification factors (immunizations recounted/reported) as a basic criteria for allocating GAVI's Vaccine Fund Shares
- Recommended potential improvements in the reporting system to managers and institutions in charge of immunization in Madagascar

Santénet took part in the meeting with the GAVI team to prepare its second round as well as the DQD survey in October 2005. The survey determined the verification factor of Madagascar was 1.002, exceeding the minimum threshold (0.800) for GAVI support, making Madagascar eligible for GAVI's second round. (In 2003, Madagascar did not meet the minimal requirement.) This allowed for improved planning of EPI activities for 2006 and finalizing the contract with GAVI to fund procurement of DTPHepB3.

ENSURE THE PROPER FUNCTION OF THE COLD CHAIN FOR EPI (ACTIVITY 2.1.5)

In October 2005, Santénet collaborated with the IACC logistics subcommittee to improve supply chain coordination by conducting

- A survey on EPI logistics
- A Vaccine Management Assessment
- An assessment of the cold chain performance in six regions in 2005
- Monitoring the implementation of recommendations

The IACC's logistics subcommittee also worked with Santénet to develop an EPI logistics reference manual for Madagascar and job aids for CBHC health workers. This improved conformity to standards and procedures in the EPI's five components: planning, vaccine management, cold chain, immunization safety, and epidemiological surveillance.

Santénet takes part in the regular meetings of the IACC's technical committee. Santénet carried out a Vaccines Management Assessment using WHO/UNICEF methodology. Data were collected in a representative sample of service delivery points from a representative sample of RHDs. The EPI logistics assessment provided a snapshot of the current situation at each level (central, intermediate, health facility) on the quality of management of vaccines, supplies, and the cold chain. Another survey is planned for 2006 to measure the impact of MOH/FP actions that are based on recommendations from the 2005 survey results. The survey will use data collected through the 2006 EPI external review in a similar number of DHS and sites, using the same data collection tools.

	Year 2003			Year 2005			Year 2006		
	Central	Intermediate	Peripheral	Central	Intermediate	Peripheral	Central	Intermediate	Peripheral
Availability of vaccines	3.3	2.1	2.0	3.3	3.7	2.1	5.0	4.2	3.8
Monitoring of vaccines and supplies stocks	1.0	0.4	0.0	3.0	2.2	1.1	5.0	4.1	3.8
Reliability of the cold chain	2.5	2.4	2.4	2.5	3.5	3.2	3.0	3.1	3.4

Each indicator is measured on a scale of 0 to 5. All indicators of vaccines, supplies availability and cold chain reliability significantly improved from 2003 to 2006, indicating the effectiveness of Santénet's support to EPI and cold chain.

SUPPORT EPI DATA MANAGEMENT THROUGH THE USE OF COMPUTERIZED MANAGEMENT TOOLS (ACTIVITY 2.1.6)

Santénet supported the routine immunization program in 111 districts by organizing workshops to train regional and district-level managers in the use of self-assessment tools for EPI DQC and the use of the computerized tool for managing vaccines, information, and the cold chain. The workshops trained managers in the DHFPS from 15 Regional Directorates (Analamanga, Vakinankaratra, Bongolava, Itasy, Atsimo-Atsinanana, Vatovavy Fitovinany, Haute Matsiatra, Ihorombe, Amoron'I Mania, Atsimo Andrefana, Menabe, Androy, Anosy, Alaotra Mangoro, Atsinanana) and 75 DHS, attempting to inculcate a culture of data for decision making and feedback.

Santénet contributes to the coordination of the routine EPI data management. Analysis of available information showed a positive link between the availability of tools and data quality at each level: the more a level uses computerized management tools (after training), the better its data quality.

Gaps in the EPI Management Information System (MIS) compelled partners to provide technical support to the Immunization Unit using data for improved decision making. The training allowed EPI managers at the district level to acquire technical skills in data for decision making (DDM) for immunization, enabling them to validate immunization coverage figures, better manage the immunization program, and create a management mechanism (for monitoring the cold chain, vaccines and key program indicators).

Taking part with MOH/FP in the International Conference "Countdown for the MDGs" in London, December 2005.
As a signatory to the Millennium Declaration, Madagascar is strongly committed to reducing child mortality (MDG 4) by two-thirds and to improving maternal and neonatal health (MDG 5). To achieve MDG 4, an international conference was organized by several partners working in MCH to present progress towards implementing priority activities in each country. Santénet developed a document presenting achievements and challenges in achieving MDGs 3 and 4 in Madagascar and participated in the conference, "*Countdown for the MDGs – 2015*" which monitored progress in child survival.

ENSURE ADEQUATE SUPERVISION OF OPERATIONS FOR THE EPI PROGRAM (ACTIVITY 2.1.7)

Santénet's support to the MOH/FP was critical in strengthening the immunization system, building on successes and lessons learned in developing child health strategic focuses, introducing zinc, and updating the Profiles data.

Santénet took part in the MOH/FP's initiative to review EPI in August 2006. Given the low coverage rate in Toliara province, and the detection of two cases of suspected polio, the GOM and the EPI IACC partners decided to conduct a polio vaccination campaign to stop the

poliovirus. The second round took place in October 2005 in one DHFPS of Ihorombe (Lakora) and four DHFPS of Atsimo-Andrefana ((Midongy, Ampanihy, Farafangana, Vagaindrano). Santénet provided technical and financial support to the five DHFPS for the campaign. Financial support focused on training and field supervision.

The anti-polio campaign contributes to Madagascar's efforts to be certified as a polio-free country. The campaign has the extra benefits of strengthening routine EPI and encouraging mothers to immunize their children. To revitalize EPI and achieve and maintain an 80 percent coverage rate for all districts, integrated formative supervision is conducted to improve quality and performance, to ensure local ownership of activities, to help health workers identify and solve problems, and to ensure appropriate use of management tools. Santénet provides technical and financial assistance to the formative supervision activities in Haute Matsiatra, Vatovavy Fitovinany, Vakinankaratra, Analamanga, Bongolava, and Itasy regions.

PARTICIPATE IN NATIONAL VITAMIN A AND DEWORMING CAMPAIGNS (ACTIVITY 2.1.8)

Santénet provided technical and financial support to epidemiological surveillance. The project provided technical and financial support to the vitamin A distribution in Atsimo Andrefana, Atsimo Atsinanana, and Ihorombe regions in 2005 and 2006 (the 2005 campaign was coupled with the anti-polio initiative) and the neonatal tetanus elimination campaign in 2005 and 2006 in the Ampanihy DHFPS, and in Atsimo Atsinana and Ihorombe regions.

ADDITIONAL ACTIVITIES (2.1.8)

Madagascar is working to meet WHO's objective to eliminate neonatal tetanus. A national plan for the elimination of neonatal and maternal tetanus was developed in 2002 and updated in 2005.

By definition, a country has eliminated neonatal tetanus when there is less than one case per 1,000 live births nationally. As cases are under-reported, it was not possible to know the disease's real incidence. Therefore, Madagascar decided to implement an additional approach besides immunizing all pregnant women. The approach consisted in an additional immunization campaign in 19 target districts in three waves. Santénet contributed technically and financially to the campaign by working through the Technical IACC meetings to prepare the Maternal Neontatal Tetanus/Vitamin A microplanning workshops, by supporting microplanning in four regions (Haute-Matsiatra, Atsinana, Atsimo-Atsinana and Anosy), by participating in the implementation of campaigns, the training of trainers, the supervision and training of central supervisors (EPI/Nutrition team), the supervision of the Vitamin A campaign, deworming and the Maternal and Neonatal Tetanus campaign itself in the regions of Amoron'i Mania, Vatovavy Fitovinany, Analanjirofo as well as in the DHFPS in the regions of Atsimo-Atsinanana and Atsimo-Andrefana (first and second rounds).

	1st round	2nd round	3rd round
Percentage of women immunized with Tetanus Toxoid	69.6 percent	71.2 percent	78 percent
Percentage of women protected with Tetanus Toxoid	22.1 percent	71.5 percent	74 percent

After the third round, the percentage of women immunized with Tetanus Toxoid reached 78 percent, which translates into a protection rate of 74 percent.

Highlight from Santénet Toamasina

On May 8, 2006 the Vitamin A and de-worming campaign at the national level was launched in Fenerive-Est in the Analanjirofo Region to bolster efforts to improve the region's low coverage rates. SN Toamasina provide financial support to the launch, which aimed to encourage target

populations in their communities to seek Vitamin A supplementation and to treat parasites. MOH/FP officials and multilateral and bilateral donor representatives communicated key messages on reducing maternal and child mortality and morbidity. However after the campaign, morbidity and mortality rates for children under-five and post partum have improved.

PROVIDE LOGISTICAL SUPPORT TO THE MOH/FP AND PARTNERS TO INTRODUCE THE NEW MALARIA TREATMENT PROTOCOL (ACTIVITY 2.1.9)

For information on this activity, please refer to 2.1.12.

SUPPORT THE DISTRIBUTION OF ITNS FOR PREGNANT WOMEN AND CHILDREN UNDER FIVE THROUGH THE PUBLIC HEALTH SYSTEM (ACTIVITY 2.1.10)

The DHFPS distributed the ITNs (insecticide-treated nets) planned for free distribution through the public sector. Therefore, Santénet's support for the distribution system was no longer required. From January to August 2006, the Malaria Control Unit distributed 575,000 ITNs (acquired with funding from the Global Fund's fourth round) in 31 priority DHFPS where malaria is endemic.

SUPPORT THE IMPLEMENTATION OF THE CONDOM PROGRAMMING STRATEGY (ACTIVITY 2.1.11)

Delivery of the 10 million condoms ordered by the ES/NACC started in 2005. The first wave was received in November and the second in June 2006. To date, 5,025,700 condoms have been distributed at the Regional Directorate levels, using SALAMA for public sector distribution, and associations and businesses for the private sector. There are currently about 4,974,300 condoms in stock. Santénet provides technical support to the manager of the condom distribution based on recommendations made by two consultants the project recruited. For example, identifying new points of sale for private sector brand condoms to increase their availability and use on taxi-buses.

PARTICIPATE IN THE CONTINUING FIGHT AGAINST MALARIA (ACTIVITY 2.1.12)

As of 2004, Madagascar benefited from four rounds of Global Fund funding. The Roll Back Malaria (RBM) committee was established to work in collaboration with the Country Coordination Mechanism (CCM) in the fight against malaria. The RBM partners set an objective to develop a national malaria control policy.

In this reporting period, Santénet participated in RBM committee activities and supported the Malaria control unit through financial support to the final production of the national malaria control policy, the organization of National Malaria Control Day and African Malaria Control Day. The project also provided technical support to prepare the strategic planning workshop for the Malaria Control Unit, financial support for the workshop, logistical support for the launching of the Residual Indoor Spraying (RIS) Campaign in Amoron'i Mania. In addition, the project took part in the team-building retreat for the RBM partnership, during which members clarified roles and responsibilities and organization of selected of CCM civil society representatives.

Madagascar chose to introduce a new malaria treatment regime and to use the Rapid Diagnostic Test (RDT) as for case confirmation. To introduce the new Artemisinin-based Combination Therapy (ACT), Santénet supported the MOH/FP in planning, coordinating activities, and gradual introduction. These respond to the following components of the national malaria strategy of the national policy: (1) malaria prevention though long-lasting ITN, RIS, and other alternatives such as retreating bednets; (2) operationalizing the RBM executive secretariat; and (3) developing, writing, and producing the national policy document.

CONTINUE ACTIVE PARTICIPATION IN THE TECHNICAL IACC FOR EPI PROGRAM (ACTIVITY 2.1.13)

As part of strategic and operational decision making, Santénet continued to work with other partners to improve the national routine immunization program. The project took part in each IACC meeting and Santénet staff attended technical subcommittee regular meetings. The staff also took part in establishing the Coordination Committee for Child

Health and the EPI Technical Committee.

In addition, Santénet takes part in the regular Senior IACC meetings to coordinate activities included in the EPI work plan and to determine strategies to reinforcing the program coordinating body. Quarterly meetings and the special sessions were held to (1) validate the immunization implementation plan, (2) make decisions on the EPI's strategic axes, (3) advocate for resources mobilization among donors, and (4) follow up on recommendations and monitor activity implementation (technical and financial monitoring).

EXPANDING THE WHOLESALE AND RETAIL NETWORK FOR SOCIALLY MARKETED PRODUCTS (IR 2.2)

EXPAND PRIVATE AND PUBLIC SECTOR AND NGO DISTRIBUTION NETWORKS TO ENSURE AVAILABILITY OF SOCIALLY MARKETED PRODUCTS (ACTIVITY 2.2.1)

As part of implementing the KM approach, Santénet trained Community-based Distribution Agents (CBDA) to improve availability of social marketing products. Community-based distribution starts with a training of trainers of the different KM implementing partners. The training was conducted in collaboration with PSI Madagascar who provided the CBDA with starter stock and IEC materials.

Since Santénet started, 1,820 CBDAs having been trained and are bringing social marketing products to the population. This number represents a three-fold increase in the number of distribution agents that had been trained by PSI before the KM's launch. CBDAs distribute SM brand water treatment products (Sur'eau), malaria treatment (Palustop), condoms (Protector Plus), bednets and oral contraceptives (PILPLAN). In addition they have also distributed some generic label products, Lo-Femenal, an oral contraceptive, and Ody Tazo Moka, a malaria treatment. From September 2005 to September 2006, distribution figures for social marketing products in the 81champion communes are as follows in table

Sales of social marketing products in the KMs (as of August 2006)		
Products	# of units	Increase over previous number of sales
SUR'EAU (bottle)	36,800	200%
PALUSTOP (Blister)	142,600	140%
PROTECTOR (unit)	114,000	400%
MII (unit)	119,700	1,370%
PILPLAN (tablet)	23,500	110%
Lo-Femenal (tablet)	20,200	260%*
Ody Tazo Moka (Blister)	28,200	Unknown

Of note, 28,200 blister packs of the total Palustop distributed, were provided free of charge. Furthermore, Pilplan was sometimes difficult to acquire, so Lo-Femenal was distributed in its place or in addition in some communes. Together the distribution of both Pilplan and Lo-Femenal represents the coverage of 43,700.

* over sales of Pilplan

SUPPORT NGOS WITH FP SERVICE DELIVERY SITES IN THE MANAGEMENT AND PROCUREMENT OF CONTRACEPTIVE PRODUCTS (ACTIVITY 2.2.2)

As part of revitalizing the use of IUDs, Santénet supported the MOH/FP in providing 3,200 units to seven NGOs who expressed interest and need following the first revitalization workshop held in November 2005. After receiving this initial amount, the NGOs supplied themselves at the PhaGDis at the DHFPS.

SUPPORT THE IMPLEMENTATION OF A WORKPLACE INITIATIVE TARGETING THE PRIVATE SECTOR FOR ALL AREAS OF SANTENET INTERVENTION (ACTIVITY 2.2.3)

For more information on this activity, see activity 1.2.3.

INCREASING ACCESS TO PRIORITY HEALTH SERVICES FOR REMOTE POPULATIONS (IR 2.3)

EXPAND PRIVATE SECTOR/NGO DISTRIBUTION NETWORKS TO INCREASE ACCESS OF SOCIAL MARKETING PRODUCTS TO REMOTE POPULATIONS, TARGETING PRIORITY BIODIVERSITY CONSERVATION AREAS (ACTIVITY 2.3.1)

The coverage in social marketing products in the biodiversity zones is similar to that of the other KM. As described in Activity 1.3.1, Santénet currently works with ERI in 11communes in the biodiversity zones. This number will significantly increase during the second cycle of KM with the addition of 25 communes located along the forest corridor.

Highlight from Santénet Fianarantsoa

Of the 23 communes in Fianarantsoa, 8 communes are located in or directly adjacent to priority biodiversity conservation areas.. In these communes a total of 173 CBDAs have been trained to distribute of the social marketing products. Additionally, SN Fianarantsoa supported ERI and PSI Madagascar to establish a distribution hub for social marketing products in Kelilalina commune within the priority biodiversity conservation zone. Furthermore, members of the Fianarantsoa Eco-Regional Alliance have collaborated with ERI and SN for promoting population-health-environment messages in priority biodiversity conservation areas.

SUPPORT THE IMPLEMENTATION OF BASIC MEDICAL COVERAGE STRATEGY (ACTIVITY 2.3.2)

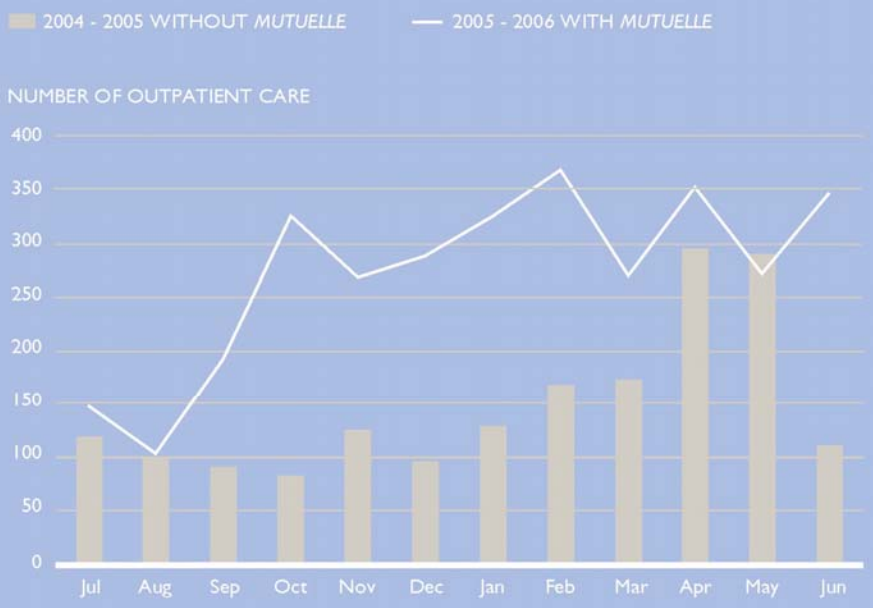
With technical support from MCDI, Santénet supports two systems as part of promoting basic medical coverage: the Equity Fund and the health mutuelle insurance schemes. In Madagascar, people may seek medical treatment from a number of providers: public health centers, private clinics, or traditional healers. Their choice is heavily influenced by cost and different payment methods, proximity and convenience, and patient perception of provider quality. Ninety percent of Madagascar's rural population is made up of farmers whose incomes are based on the growing season. After a harvest, families have disposable income to pay for healthcare; however, during the lean season when money is scarce, farming families are less likely to seek care.

In 2004, there was no strategy to provide care to needy populations and free access to care at the CBHC level was not regularly available. The FANOME was established as a cost recovery system for drugs. National health accounts reveal the health system is GOM-funded for operational expenses, by partners through projects and budget support, and by households through the cost recovery system. The existing system excludes the poorest of the poor and seasonally vulnerable groups. To meet those needs, Santénet took part in implementing the Equity Fund component for CBHCs, in the design of a hospital-level Equity Fund, and provided technical and financial support in establishing the health insurance schemes, or *mutuelles*.

The Equity Fund at the CBHC level.

Santénet's support to the Equity Fund at the CBHC level last year yielded the following results:

CBHC MAHADITRA: MONTHLY OUTPATIENT CARE

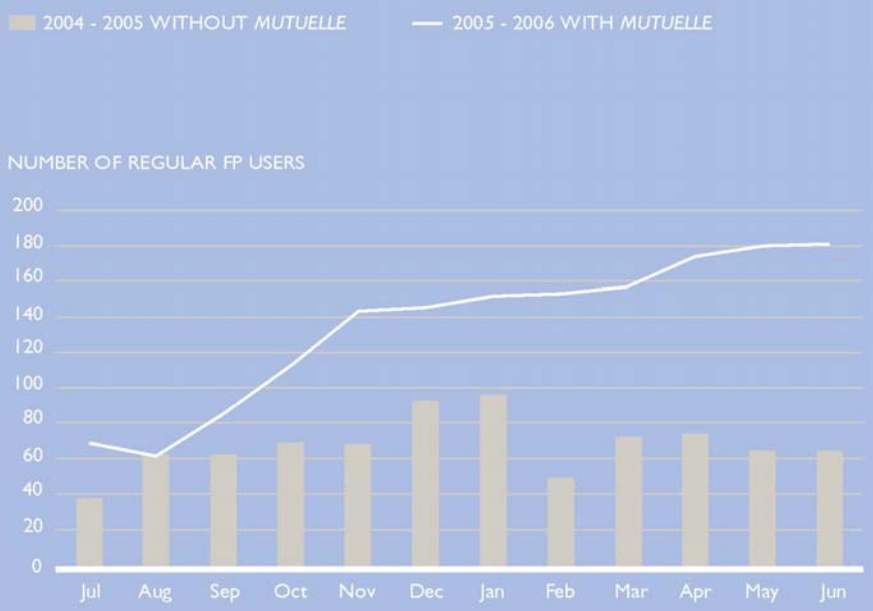


ABOUT THE GRAPH: The graph shows how health *mutuelles* improve utilization rates of health care centers during the lean period which lasts from September to March

CBHC TALATA AMPANO: MONTHLY DPTHEPB3 VACCINATION

ABOUT THE GRAPH: The graph shows how health *mutuelles* boost immunization coverage

CBHC AMBALAMAHASOA: MONTHLY FP REGULAR USERS



ABOUT THE GRAPH: The graph shows how Health *mutuelles* contribute to increase number of regular FP

- Initiated the establishment of the basic health coverage system, to decrease economic barriers and increase access to health care
- Assessed the cost of services provision for the poorest of the poor who likely did not seek any care previously: out of 95,090 people who meet eligibility requirements, 14 percent benefited from the Equity Fund
- Drew the conclusion that cumulative EF revenues covered the costs for treating all the identified needy people
- Found that the community is becoming effectively involved in managing health matters

The Equity Fund at the Hospital level. Santénet provided technical support to the MOH/FP, more specifically to its Regional and Referral Hospital Directorate, in developing the hospital-level Equity Fund. The following activities were conducted as part of this support: (i) constructing a database of unit costs (i.e. pharmaceuticals, medical supplies, tests) that could be covered under the hospital Equity Fund (District Hospital II, Regional Referral Hospital, Teaching Hospital), (ii) reviewing and validating treatment protocols, (iii) calculating the costs of pathologies eligible for the Equity Fund, (iv) finalizing costs of the different packages, and (v) scenario-building for different service packages. These activities were conducted to make a policy decision and to prepare a plan to implement the Equity Fund at the hospital level.

Health mutuelles. As a large portion of the rural population are seasonally vulnerable and based on past experiences in community pharmacies in supply and use of medications, the RHFPD managers in Haute-Matsiatra requested Santénet's support in revitalizing these *mutuelles*. Through its technical and financial support, Santénet significantly contributed to this effort to improve access to care through the following activities:

1. Participatory situation analysis, building on the region's achievements in terms of health insurance schemes
2. Drafting and pre-testing guides for establishing the *mutuelles*
3. Participating in the development of (1) the M&E plan, (2) the actuarial calculation model, (3) the finalization of the package's cost calculation, and (4) the survey sampling plan
4. Piloting *mutuelles* in five communes of Fianarantsoa II's DHFPS
5. Developing the guide for establishing health insurance schemes in Madagascar
6. Scaling up the health *mutuelles* in the regions of Haute-Matsiatra (49) and Vatovavy-Fitovinany (14)
7. Establishing pilot *mutuelles* in the regions of Ihorombe (3), Atsimo-Atsinana (12), and Amoron'I Mania (9)
8. Training of nine trainers from the Regional Management teams and 67 mangers from the District Management teams on the promotion, implementation, and supervision of *mutuelles*
9. Presenting the partial results of the *mutuelles* of Talata Ampano at the American Public Health Association annual conference.
10. Organizing an open house on *mutuelles* and beginning to scale up in Fianarantsoa in collaboration with the Haute Matsiatra Regional Health Directorate
11. Monitoring the activities to establish health *mutuelle* in Fianarantsoa: planning (Haute Matsiatra, Vatovavy Fitovinany; Amoron'i Mania, Ihorombe; Atsimo Atsinanana)
12. Developing management tools for the *mutuelles*

Highlight from Santénet Fianarantsoa

Health mutuelles were officially launched at an open-door event in Fianarantsoa on March 24, 2006. The event offered an opportunity to underscore with government officials the importance of mutuelles to ensure availability of health products in the BHCs by developing a collective sense of responsibility. Representatives of regions with mutuelles were invited to talk about the success of the mutuelle in their community, including DHS managers in the Haute-Matsiatra region, mayors of 22 communes, mutuelle committee members and subscribers from each of the operational schemes.

INCREASING THE NUTRITIONAL VALUE OF AGRICULTURAL PRODUCTS (IR 2.4)

UNDERTAKE A FEASIBILITY STUDY FOR THE INTRODUCTION "ORANGE-FLESHED SWEET POTATO" IN TARGETED KM COMMUNES (ACTIVITY 2.4.1)

Ny Tanintsika, one of Santénet's partner NGOs for KM in Fianarantsoa, has already introduced the orange-fleshed sweet potato in some of its communes. Seedlings were grown from January to March 2006 and the plants were then planted and were harvested in August-September 2006. The communes were happy with the resulting plants.

Santénet is negotiating an MOU with the research institute FIFAMANOR for the production of plants, training of trainers, and the development of a training guide. FIFAMANOR will contribute to establishing a demonstration plot in the commune of Anjeva Gara as part of the official launching of the NGO PENSER. The first draft of an action plan was submitted in September as part of scaling up this new crop in three KM by the end of 2006.

Santénet contracted with a locally based NGO, AgTech, to conduct a feasibility study for the introduction of orange-fleshed sweet potatoes in three regions: Taolagnaro (Fort-Dauphin) in six CCs supported by ASOS Sud, in Ambatondrazaka in two communes supported by Mateza, and in Vatomandry in four communes supported by CARE. The first field visits conducted a summary analysis of the local economic and food security situation, analyzed the growing seasons of each target area in order to determine the optimal date for introducing the plants, identified model farmers, visited target communities, and selected pilot plots. The visits found that each region was familiar with sweet potatoes and willing to eat them, and that there were two possible growing seasons in Taolognaro and just one in the other regions. In Taolognaro, it was noted that farmers were only interested in a new product if it would improve their income and/or their food supply.

IMPROVING WATER MANAGEMENT FOR AGRICULTURE AND HOUSEHOLDS (IR 2.5)

IMPROVE THE ENVIRONMENTAL HYGIENE AND SANITATION COMPONENT (INCLUDING PROMOTION OF THE SUR'EAU) THROUGH AN INTEGRATED PLAN OF ACTION (ACTIVITY 2.5.1)

To promote the link between water, sanitation, and health, Santénet has coordinated with the Hygiene Improvement Project (HIP) project to ensure that proper sanitation messages and practices are being introduced, and has facilitated the promotion of Sur'eau to improve access to clean water in the country. Activity 2.2.1 discussed promotion of Sur'eau as part of the range of socially marketed products

Santénet has additionally worked with the WASH *(Water, Sanitation, and Hygiene)*/HIP project. During the WASH/HIP workshop in February, Santénet agreed to incorporate water and sanitation messages in KM tools and activities. These messages correspond to actions that are feasible in the target communes. Furthermore, Santénet contributed to the formation of the WASH committee in Fianarantsoa in January of 2006 that contributes to reducing waterborne diseases in Madagascar — specifically diarrhea, which is one of the three main causes of child morbidity and mortality. The objective of the committee is to mobilize authorities, technical and financial partners, and all relevant players to prioritize the population's access to water, sanitation, and hygiene. Santénet and HIP completed negotiations for HIP to share Santénet's Antananarivo office space beginning in October 2006.

Santénet, in collaboration with ERI, recruited a water and sanitation consultant to begin working with the KM to expand the use of integrated sanitation and hygiene, contribute to the advancement of the WASH initiative and provide technical assistance in areas of latrine building, spring capping,

implementation of gravity flow water systems, and simple irrigation dam design in Fianarantsoa and Toamasina, starting in October 2006.

Highlight from Santénet Fianarantsoa
SN Fianarantsoa has been instrumental in establishing WASH (Water, Sanitation, and Hygiene) committees in their region to advocate for access to clean water and promote hygiene. In January 2006, SN Fianarantsoa helped to train the provincial WASH committee. The WASH committee is composed of more than 30 members representing local and international NGOs, government ministries, and USAID projects. In September 2006, the committee reorganized from a provincial to a regional group for the Haute Matsiatra Region. The committee works to reduce water-borne disease in Madagascar, especially diarrhea, which remains one the three main causes of morbidity and mortality among children under-five, and seeks to mobilize government officials, technical and financial partners, and all relevant players at all levels in prioritizing the population's access to water, sanitation, and hygiene. The regional committees are the representation of the WASH structure at the regional level based on the administrative organization. They develop WASH activities, liaise with the National Committee and take part in the general assemblies. Regional committees have been formed in one additional region, with plans to form in the three other regions of the province this year.

RESULTS AND IMPACTS IN 2005 – 2006

FP was integrated into the GED. Family planning has been integrated into the GED, resulting in almost 100 percent of the DHFPS having placed accurate and effective orders for their contraceptives commodities in Q4 2005 compared to 56 percent in 2004, when the system to improve contraceptive supply chains was first implemented. Other milestones included: regular monthly and quarterly reporting and dissemination of commodity stock/needs was implemented; the Contraceptive Security Strategy Document was developed and approved; contraceptive needs have been forecasted through 2008; and for the first time the GOM is contributing funding for contraceptive procurement in 2006 and 2007, a key step in the long term sustainability of the contraceptive security.

FP Partners Committee was established. The FP partners' committee was established, through which the contraceptive commodities procurement plan for 2005 was endorsed, and results from the FP Logistics survey were shared. This led to a second meeting, in January 2006, during which (1) the contraceptive commodities procurement plan for 2006 was validated, and partners guaranteed the funding, (2) the implementation tools for IUD revitalization were finalized (curriculum revision, TOT, training, etc.)

Up-to-Date information on FP was shared. To strengthen the supply of long-term family planning methods, the reference manual, the participant's workbook, and the trainer's workbook were updated to reflect new WHO guidelines, and trainers in IUDs were trained. Furthermore information was shared regarding current trends and topics including logistics management of contraceptive commodities, LTPM, specifically IUDs and Implanon, the application of RRI to FP.

Availabilty of FP was improved. The 2006 FP logistics survey showed excellent results regarding the availability of contraceptive commodities in PhaGDis and service delivery points and with regards to an increase in consumption as recorded in the service registers. Table 3 below demonstrates this decrease in stockouts of the most popular form of contraceptive, the injectable Depo-Provera injectables, following the repositioning of FP in December 2004. Demand for Depo Provera at the CBHC level has also sharply increased throughout the same time period, as seen in table 4, as a result of improving service and product supply. Furthermore, while we do not have complete results for all sites, of the 106 sites that implemented RRI/FP, 38 (35.6 percent) have reported achieving their objectives for the 100th day.

Table 3: Stock-outs of Depo-Provera at the PhaGDis and CBHC level

Stock-outs of Depo-Provera	*2004*	*2005*	*2006*
PhaGDis	20 %	20 %	13 %
FP sites	14 %	18 %	4 %

Table 4: Trends in Depo-Provera consumption at the CBHC level

Depo-Provera consumption	*2004*	*2005*	*2006*
Trends	4.29 %	26 %	17 %

All the efforts made to support the national FP program have resulted in strengthened capacity among managers and service providers at the central, regional, district, and service delivery point levels. Thus, the range of available methods has expanded with the introduction of Implanon and SDM, the sources of services have become more diverse (expansion of the social marketing network, many community-based workers providing FP services), the availability of contraceptives commodities have clearly improved at the service delivery points with tangible decreases in the number of stock outs. In turn, these improvements have resulted in sustained consumption increase.

EPI Performance was improved. To improve EPI, Santénet equipped the 111 DHFPS with standard EPI management tools (tally sheets, mother's card, child's card, immunization diploma), and the implementation of RRI pushed DHFPSs to reach their goals of improving EPI performance. In the last quarter of 2005, the number DHFPS achieving their immunization coverage objective (more than 80 percent) increased from 50 in September to 59 in December (Table 5). Concurrently, the number of those who remained below 50 percent sharply decreased to seven DHFPS. Additionally, Madagascar was approved by GAVI for a second round of funding through 2012 because of results from and external DQC, ensuring support for immunization services.

Table 5: Trends in EPI performance in Santénet's intervention zones – over the last three months of 2005 under RRI/EPI

Number of districts with :	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
=> 80 percent of monthly objective	45	44	45	46	44	45	44	47	50	51	53	59
50≤ 3 ≤79 percent of monthly objective	16	19	20	22	24	24	25	23	19	19	21	15
< 50 percent of monthly objective	20	18	16	13	13	12	12	11	12	11	7	7

Social Marketing Products to prevent and treat common causes of maternal and child illness were distributed. Activities this year to address malaria allowed for an operational partnership with RBM, formalizing Madagascar's CCM in accordance with the Global Fund requirements, and publishing the National Malaria Control Policy. In addition, 120,000 ITNs were distributed through the CBDA network in 81 KMs, a number that is 13 times the number sold in September of 2005. Other social marketing products were also made available in all KMs through the efficient partnership between Santénet, PSI, and partner NGOs, improving access to methods for preventing diarrheal diseases, preventing and treating malaria, and family planning in the communes. The table on page 36 summarizes sales as of August 2006, and demonstrates the marked increase in availability of all items.

Health Financing schemes improved access to care. Mutuelles and Equity Funds, the health financing schemes implemented by Santenet, decrease financial barriers to seeking health care services. This has improved availability of care for many Malagasy people, how often make less than on dollar a day. As seen in Table 6 below, more than 13,000 people have benefited for the Equity Fund at the primary care level after just one year of implementation (July 2005 to June 2006)

Table 6

	Antananarivo	Antsiranana	Fianarantsoa	Mahajanga	Toamasina	Toliara	Total
Total income FANOME MGA	1,386,927,688	383,306,510	1,326,200	421,568,353	774,768,636	938,798,858	**5,231,570,878**
Income Equity Fund (MGA)	77,236,825	25,790,873	46,358,150	40,683,303	78,797,882	44,867,900	**313,734,933**
Total of number of qualifying recipients	19,136	6,262	12,303	14,983	19,500	22,906	**95,090**
Total of qualified benefiting from coverage	4,518	106	1,898	2,093	1,626	3,043	**13,284**
Average cost per case **MGA**	1,287	1,469	1,168	1,522	1,158	643	**1,146**

The mutuelles implemented by Santenet this year contributed to:

- Establishing a medical coverage system
- Effectively involving communities in health care management
- Increasing use of outpatient consultation during the lean period
- Improving health indicators (immunization coverage, contraceptive coverage, PNC) in the CBHCs by requiring preventive measures by members
- Developing a premium calculation models and a monitoring and evaluation plan for mutuelles

Two community mutuelles underwent in-depth assessment using three data sources: CBHC outpatient consultation registers, Mutuelle accounting books, and system, household survey and program leader survey data. Parametric analysis of members and non-members showed an increased use of services by members during the lean season. Increases were noted in the percentage of children receiving routine vaccinations (BCG, DTPHepB3, VAR), Vitamin A supplementation and deworming medicine, as well as the percentage of women who are receiving tetanus vaccinations, iron/folic acid supplement, and who received qualified assistance at delivery. Bringing Santenet to the conclusion that Mutuelles have increased in the use of outpatient consultation during the lean period. This increase in coverage has further been improved by the scale up of mutuelles in the province of Fianarantsoa. In August 2006 the total number was increased to 87: 24 pilot sites, and 63 new sites.

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CHAPTER FIVE: INTERMEDIATE RESULT 3 (IR3)

IMPROVING THE QUALITY OF SELECTED HEALTH SERVICES

INTRODUCTION TO THE INTERMEDIATE RESULT

To increase the demand and availability of selected health services and products, health services must meet the clients' expectations for quality services, which relate to convenience, interpersonal relations, and respect of individual rights. Clinical services must also be provided according to evidence-based standards and guidelines. Consistent quality of care across public, private and NGO provider networks is essential for a coordinated national response.

IR3 addresses the development and the implementation of state-of–the-art service delivery practices through the *improvement of the quality* of health services at commune level and selected practicum sites in the four target provinces.

Improved service delivery will contribute to the promotion of family planning, improvement of child health, control of malaria and prevention of STIs including HIV/AIDS. In order to improve the quality of these selected services, the activities under IR3 are designed to improve policies, standards and protocols (PSP) for public and private health services (IR3.1), improve service providers' ability to deliver quality health services (IR3.2), and implement operational models for quality assurance (IR3.3).

*Improve procedures, standards and protocols for public and private health services (*IR3.*1).* Use of health services is highly dependent upon the quality of care provided. Quality is generally measured against accepted PSP. While some PSP exist for key child, maternal, and reproductive health programs, much need to be updated and revised to comply with the best practices recommended and accepted internationally. In other cases, PSP need to be established.

*Improve service providers' ability to deliver quality health services (*IR3.*2).* Another key area to improve quality of services delivered is through pre-service and in-service education for health professionals. Many existing PSP are not well understood by health providers and, as a result, are not appropriately implemented. Medical and paramedical training institutes in Madagascar lack resources to upgrade their facilities. Furthermore, their curricula and methodologies need to be updated as new PSP come on line.

*Implement operational models for quality assurance (*IR3*.3).* Operation models are another mechanism by which improved services can be tested and validated. Furthermore, information from the models can ultimately be used at the national level to improve PSP. If proven successful, these models can be expanded to a larger scale by other donors.

ACHIEVEMENTS 2005 – 2006

IMPROVING HEALTH POLICIES, STANDARDS AND PROTOCOLS FOR PUBLIC AND PRIVATE SECTOR HEALTH SERVICES (IR 3.1)

SUPPORT THE RATIFICATION OF THE NATIONAL RH POLICY AND THE UPDATING OF THE RH STANDARDS AND PROTOCOLS (ACTIVITY 3.1.1)

This year Santénet supported the process of revising reproductive health (RH) standards and procedures by assessing and analyzing the standards document, holding planning and consensus-building meetings to agree on the methodology for the revision, developing a work plan, and updating national experts on recent developments in RH and child health. With additional technical support from JHPIEGO/Baltimore, Santénet funded a workshop in May 2006 which made significant changes to the standards document. These changes incorporated new RH and child health technical components being introduced in Madagascar such as Implanon® and community-based promotion of injectable contraceptives, zinc, and Cotrimoxazole. Detailed description of standards and protocols related to adolescent health, domestic violence, and post-abortion care were also incorporated and the document's format was changed. The resulting draft was reviewed and edited by the Safe Motherhood Unit between May and July 2006 and then circulated to partners for further review. The MOH/FP plans to endorse the report in November 2006 following the RH technical coordination meeting.

DEVELOP DESIRED PERFORMANCE STANDARDS FOR CHILD HEALTH (ACTIVITY 3.1.2)

To improve child health service provision, Santénet organized a workshop in February 2006 for MOH/FP senior technical staff, Befelatanana Hospital maternity staff representatives, and members of Santénet's IR3 team, to draft standards for child health, based on national and international reference documents, and disseminated it to partners for feedback in March 2006. JHPIEGO/Baltimore provided editorial assistance after which Santénet organized a five-day workshop in April 2006 to build consensus around the second draft with regional focal points. Feedback from this workshop was incorporated into the final version that was submitted to the Directorate of Child Health in September 2006 for review and approval. This document has since been used to update the Integrated Management of Childhood and Newborn Infection (IMCNI) decision making tools by the ministry of health in May 2006.

IMPROVING SERVICE PROVIDERS' ABILITY TO DELIVER QUALITY HEALTH SERVICES (IR 3.2)

ORGANIZE A TRAINING WORKSHOP ON DESIGNING TEACHING PROGRAMS FOR ADVANCED TRAINERS (ACTIVITY 3.2.1)

In order to create a national and regional pool of qualified and competent trainers in curriculum development, Santénet hosted in 2005 a training of Twenty-three advanced trainers. These advanced trainers participated in a training workshop in curriculum development techniques in November 2005 with JHPIEGO/Baltimore's technical support and Santénet's financial support. During this workshop participants updated the national integrated FP training module and developed an FP reference guide, a trainer guide, and a participant guide. The revised module was tested and used during in-service training of service providers in practicum sites and in KM CBHCs.

UPDATE ADVANCED TRAINERS IN STI AND CPC/PMP (ACTIVITY 3.2.2)

In June and July of 2006, eight advanced trainers facilitated district and KM partners level trainings (described in more detail in activity 3.2.4 and other activities). These candidates had previously been trained by Santénet in FP, STI, IP, PN/IP training, and were selected to improve the capacity of local staff and for cost savings. These trainers were subsequently qualified as trainers of trainers.

UPDATE TRAINING-OF-TRAINERS CANDIDATES IN IP, FP, STI, AND CPC/PMP (ACTIVITY 3.2.3)

In June 2006, Santénet and the MOH/FP organized a one-week session in FP, STI, IP, FPC/IPT techniques for 24 candidate trainers from 22 districts and two regional Santénet offices to expand the pool of trainers that can train service providers in the DM. Four advanced trainers who were rained in 2005 facilitated the update training.

ORGANIZE TRAINING-OF-TRAINERS WORKSHOPS (ACTIVITY 3.2.4)

Twenty-four of the candidate trainers attending the STI, IP, FPC/IPT techniques training (described in activity 3.2.3.) were also invited to attend a five-day TOT training. This training was facilitated by four advanced trainers who had been trained in 2005 and then qualified as trainers of trainers.

TRAIN-THE-TRAINER SUPERVISORS IN FACILITATIVE SUPERVISION (ACTIVITY 3.2.5)

In November 2005, Santénet funded and implemented with JHPIEGO/Baltimore's technical support a training session in facilitative supervision skills for district level external supervisors and practicum site internal supervisors. Twenty-five participants were trained, including three Santénet staff members. As part of the training, to apply the skills they were learning, participants worked in regional groups developing an action plan for implementing facilitative training and application in their regions. As an opportunity to practice the skills learned at the training, five of the trained supervisors were later involved in the series of monitoring and evaluation visits in practicum sites that had introduced Quality Assurance Systems (QAS).

TRAIN THE EXTERNAL SUPERVISORS OF THE MOH/DHFPS AND KM PARTNERS AND THE INTERNAL SUPERVISORS AT THE KM CBHCs IN FACILITATIVE SUPERVISION (ACTIVITY 3.2.6)

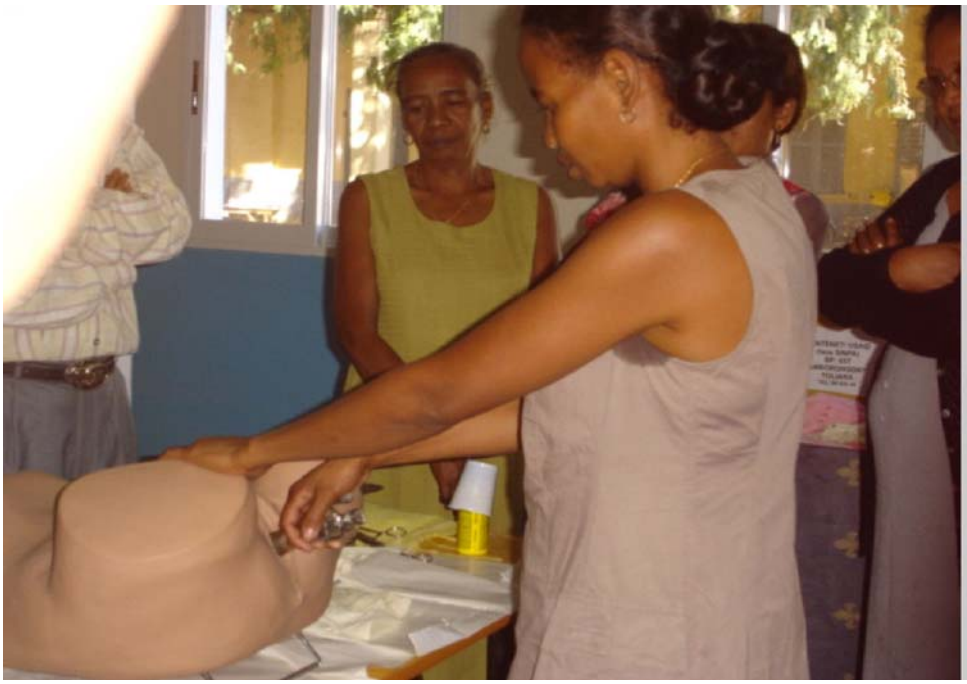
District-level external supervisors and KM CBHC internal supervisors were also trained in facilitative supervision skills. Two five-day training sessions in September and October 2006 included 44 participants. The training covered the role of supervisors under the QAS/PQI process, efficient team work, and M&E of CBHCs applying the QAS. The training provided an opportunity for participants to develop work plans for implementing the skills learned at the trainings. Two supervisors from Fianarantsoa and Toamasina facilitated the sessions under the guidance of a Santénet trainer. As follow-up to this training, some participants will be involved in the training of supervisors in the new DM in 2007, monitor the application of the QAS in the KM CBHCs, and supervise trained providers. Santénet will also support implementation of the action plans developed during the training.

UPDATE THE SERVICE PROVIDERS FROM THE KM COMMUNES' CBHCs (ACTIVITY 3.2.7)

In 2006 QAS action plans identified several overarching training needs in KM CBHCs. To respond to those needs, 130 service providers from 50 CBHCs received in-service training in FP, using the newly revised integrated FP, IP, and STI modules that had been updated by Santenet and MOH/FP. Eight sessions were organized from August to September 2006 to provide participants with skills in these three technical areas. As a result, 23 of 46 candidate trainers were certified. The remaining 23 candidate trainers are expected to be certified in 2007 during TOTs scheduled in the nine DM.

MONITOR TRAINEES (TRAINERS AND SERVICE PROVIDERS) (ACTIVITY 3.2.8)

To improve the quality of services provided by the 42 trainers and



SANTENET 2006

LEFT: In order to help the CBHCs implement their QAS action plans, Santénet provided in-service training in FP to 130 service providers using the newly revised integrated FP, IP, and STI modules updated by MOH/FP and Santénet.

providers trained this year, the trainers were monitored as part of their certification. As part of this training and follow-up, three master trainer candidates took part in the developing and revising the IUD training module, two in the revision of the decision making tools, and four in updating the RH standards and procedures. These activities counted towards their qualification as master trainers, while also contributing to achieving Santénet's objectives. In addition, eight advanced trainer candidates, 23 trainer candidates, and two regional supervisors who had attended trainings went on to be qualified this year.

To assure quality from the large number of service providers trained in 2005 and 2006, trainers were monitored by the MOH/FP through quarterly routine supervisory meetings organized at the district level. These meetings charted the progress in completing the action plans developed during training and identified any problems the service providers had encountered in applying their skills. The monitoring visits often ended with a small refresher lecture and recommendations for improving service provision. Santénet also conducted follow-up when conducting other field activities.

PROVIDE APPROPRIATE TEACHING MATERIALS FOR THE PRACTICUM SITES TO SUPPORT SUPERVISION OF THE STUDENTS (ACTIVITY 3.2.9)

To facilitate the instruction of medical students, Santénet purchased training materials and models to meet a need expressed by institutions and practicum sites in 2005. These materials were distributed to six paramedical schools, 10 practicum sites, the maternal health department at the MOH/FP, and the Maternal and Child Health Department at the medical school.

In addition Santénet procured additional reference materials to be used by medical training staff and students. Santénet also received 200 copies of a document and CD-ROMs on standards-based management, which were distributed during the advocacy and orientation meetings in the DM. A reference document on effective teaching was also translated from English into French and used to train faculty and instructors. Two hundred copies were printed and distributed to participants from the paramedical schools and medical school attending a training workshop referred to in activity 3.2.12

ORGANIZE REFRESHER COURSES FOR SERVICE PROVIDERS AT THE PRACTICUM SITES (ACTIVITY 3.2.10)

In order to meet additional needs identified in the QAS action plans, a five-day training session on FP was organized for the seven sites in Antananarivo in December 2005. A second training session for the same sites was held in January 2006, covering STIs. These training activities were then repeated for the five regional practicum sites in February. In total, 35 service providers were trained in FP QAS and 27 in STI QAS. These training activities contributed to improving the performance and the quality of services

in the practicum sites as shown in the tables under activity 3.3.3.

SUPPORT THE REVISION AND PRODUCTION OF IMCI AND ENA TEACHING TOOLS (ACTIVITY 3.2.11)

Santénet provided technical and financial support to paramedical and medical schools in developing the national protocol for supervising IMCNI and Essential Nutrition Actions (ENA) and the IMCNI decision making tools. Documents were developed in collaboration with the Child Health Department at the MOH/FP along with representatives from WHO, the National Public and Community Health Institute, and the maternity ward of Befelatanana Hospital. Two workshops were organized to draft the protocols. Similarly, the IMCNI decision making tools was revised during a five-day workshop. As a result, the national protocol for supervising IMCNI was revised, printed, and distributed. The decision making tools has been finalized and is expected to be approved during a Santénet/WHO joint workshop planned for 2007. The revision of the IMCNI in-service training curriculum that was initiated in 2006 will continue into 2007, along with the finalization of the appendices for the national supervision protocol with technical and financial support from Santénet.

TRAIN THE IMCI SUPERVISORS, EVALUATORS AND TEACHERS AT THE PARA-MEDICAL TRAINING INSTITUTION AND FACULTY OF MEDICINE IN EFFECTIVE TEACHING SKILLS (ACTIVITY 3.2.12)

In November 2005, two training sessions were organized to build effective teaching skills among faculty and instructors. The session trained a total of 46 medical school faculty members and 48 paramedical school instructors. The goal of the training sessions was to assist faculty in supporting the implementation of the training modules in their respective departments, in particular IMCNI and ENA. Participants developed actions plans whose implementation will be monitored by Santénet during supervisory visits.

Without supervisory support and commitment from colleagues, participants could not effectively apply their newly-gained knowledge and skills. Therefore, Santénet plans in 2007 to advocate among deans to increase their support and institutionalize these teaching techniques. Through such advocacy, the Maternal and Child Health Department at the medical school has committed to applying the methods learned during academic year 2006-2007.

TRAIN THE MONITORS AND SUPERVISORS IN ESSENTIAL NUTRITION ACTIONS (ACTIVITY 3.2.13)

Please refer to Activities Not Completed

REVISE THE EMERGENCY OBSTETRIC AND NEONATAL CARE (EONC) TRAINING CURRICULUM FOR HOSPITALS (ACTIVITY 3.2.14)

Please refer to Activities Not Completed

PROVIDE MONITORING FOR TRAINEES (TRAINERS AND SERVICE PROVIDERS) (ACTIVITY 3.2.15)

Please refer to Activities Not Completed

OTHER ACTIVITIES COMPLETED

In addition to the training activities described above, the IR3 team organized a one-week TOT in clinical techniques for partner NGOs' trainers in July 2005. Twenty-two trainers were selected and trained in the most recent infection prevention (IP) techniques and clinical training skills. As a result a larger pool of trainers is now available to assist NGOs and the MOH/FP in training of trainers and subsequently four other advanced trainers were qualified as trainers of trainers.

A member of the IR3 team also supported the MOH/FP in training activities on the use of Implanon® in two regions and in pre-testing the revised IUD training module. Such good collaboration shows exemplifies the MOH/FP's confidence in Santénet and its staff.

IMPLEMENT OPERATIONAL MODELS FOR QUALITY ASSURANCE OF SELECTED HEALTH SERVICES (IR 3.3)

ENSURE MONITORING OF ACTION PLAN IMPLEMENTATION AT THE PRACTICUM SITES (ACTIVITY 3.3.1)

The 10 practicum sites developed PQI action plans to improve quality service provision to address gaps in PQI and had been receiving technical and financial support from Santénet to implement them. Each site was visited twice between December 2005 and January 2006. As part of the first visit, the sites received recommendations from supervisors. During the second visit, it was noted that 80-95 percent of the action plans had been implemented.

PROVIDE CHLORINE-MANUFACTURING EQUIPMENT TO FOUR REGIONAL HOSPITALS (ACTIVITY 3.3.2)

A significant need for chlorine for sterilization purposes had been identified in the practicum sites, so Santénet decided to provide the sites with chlorine manufacturing equipment. Before procuring the machines, a feasibility study confirmed that the human and raw material resources were available at all the sites. Electric machines supplying a daily output of 200 liters of chlorine were selected and the first was delivered and installed in July 2006 in Toliara. As a result, chlorine was made available to the CBHCs in the surrounding area. Consequently 10 other machines will be installed in December 2006. In October, 2006, Santénet will monitor the operation of the machine and the supply of chlorine to the surrounding CBHCs during visits to launch QAS in the new DM.

Highlight from Santénet Toliara

With the arrival of the chlorine production machines in Tulear, Santénet trained a staff member to install, operate and maintain the machines. The instructions were translated into Malagasy. This technician will now be able to train others in the use of the machines and their installation in other locations as Santénet continues to provide machines to health centers.

CONDUCT QAS/PQI EVALUATION VISITS (ACTIVITY 3.3.3)

In March 2006, monitoring visits were conducted with technical support from JHPIEGO/Balitmore and the IR3 team in 10 practicum sites to assess performance improvements in IP, FP, and STI. Results proved to be highly satisfactory. The 10 sites achieved an average 67 percent of the standards in all three of the technical areas, exceeding the basic minimum standard of 40 percent. Specific progress is charted in the tables on page 50 and in the IR3 results section.

INTRODUCE PQI IN THE MENDRIKA COMMUNES' CBHCs (ACTIVITY 3.3.4)

The introduction of PQI is planned for 147 CBHCs in all 81 KMs. These were classified by Santénet into three categories: 40 Category 1CBHCs with at least two or three staff members; 49 Category 2 CBHCs, having one or two staff members; and 58 Category 3 CBHC with only one staff member. Given the number of possible CBHCs in which to implement PQI, 40 Category 1 and 10 Category 2 CBHCs were selected. Category 3 CBHCs and sites without electricity or running water do not meet the minimum criteria to implement PQI. External evaluations will be conducted in the Category 1 sites and providers will self-evaluate in Category 2 CBHCs.

To implement this approach, the following activities were conducted:

- Thirty-nine CBHCs were visited in October and November 2005 to assess needs. Santénet used this as an opportunity to familiarize regional administrative and health managers (heads of districts and their deputies, representatives of the regional level of the MOH/FP, health districts, and heads of health posts) on the QAS process. Fifteen of the 39 CBHCs visited were in good physical condition, 17needed paint, and seven needed to be entirely rehabilitated.

- PQI evaluation teams were trained in December 2005 and January 2006 and community leaders were educated in the approach.

PQI EVALUATION STI

ABOUT THE GRAPHS: The graphs show the achievement rate for meeting standards for STI, PF and IP in the practicum sites.

PQI EVALUATION PF

PQI EVALUATION IP

- Four workshops were organized in December 2005 and January 2006 in Toliara, Toamasina, and Antananarivo and were attended by community representatives. One hundred people were trained on the QAS methodology based on the QAS/PQI approach. At the end of each training workshop, province and evaluation teams created a plan to introduce PQI.

Forty-six of 50 CBHCs were assessed from January to April 2006. Four centers could not be assessed as one did not have staff, two in Toliara were inaccessible during the evaluation period due to rain, and one had merged with another CBHC. MCDI and district-level evaluators introduced the self-assessment approach in the 10 Category 2 CBHCs. To date, Santénet has received 43 of the 46 action plans.

Service providers were given IP refresher training in FP and STIs, and IP kits will be distributed upon arrival of the Individual Protection material (such as masks). Including mayors in the process has helped to address many health center problems by purchasing chlorine, building fences, caring for yards, and building waiting benches.

SCALE UP SDM IN THE PUBLIC AND PRIVATE SECTORS (ACTIVITY 3.3.5)

Santénet has support the MOH/FP in assessing the pilot project on the Standard Days Method (SDM) and to scale up its use the country. The method was introduced in 27 health centers in July 2005. After 10 months of implementation, the intervention was assessed by the National Public and Community Health Institute in April and May 2006. As a result, 624 women adopted the method and a workshop to share results was organized in late June 2006.

In September 2006, a consultant from the Georgetown University Institute for Reproductive Health (IRH) assisted in developing the scale-up plan. During the consultant's mission, an advocacy effort was made jointly with the MOH/FP, targeting multilateral institutions, bilateral donor agencies, and international and local FBOs to secure their support in the SDM scale up. All expressed their interest in expanding SDM, either through support for training (African Development Bank and USAID), procuring the cycle beads (UNFPA and World Bank) or any other support the MOH/FP may need (UNICEF and GTZ). Meanwhile, the MOH/FP integrated SDM into the integrated FP training module, RH standards and procedures documents, and in the FP statistics data collection formats.

The data collected on SDM users for the period July 2005 to September 2006 are found in the following table. New users are women who had never used an FP method and old users are women who had used contraception previously but not in the past three months.

OTHER ACTIVITIES COMPLETED

Santénet organized a study tour in

SANTENET 2006

LEFT: In order to scale up the Standard Days Method nationally in 2007, MOH/FP, Santénet and the other FP partners have agreed to integrate SDM into the integrated FP training module.

Malawi for the MOH/FP QAS coordinator to observe the IP program that JHPEIGO is currently implementing with the Malawi Ministry of Health. Following the visit, the coordinator was inspired to replicate the program for the Malagasy hospitals. A joint action plan was developed to introduce IP in seven hospitals selected in Santénet's intervention zones.

ACTIVITIES NOT COMPLETED IN 2005 – 2006

As part of its collaboration with Santénet, the Linkages Project has committed to updating the paramedical schools on ENA, activity 3.2.13. This partnership is ideal given their expertise, and because Linkages had previously revised the ENA module.

Activity 3.2.14., Revise the emergency obstetric and neonatal care (EONC) training curriculum for Hospitals, was not implemented because of the technical and geographical breadth of the activity, the resulting technical and financial constraints, and UNFPA's previous activities in the area.

We were not able to supervise the implementation of faculty and instructor action plans described in activity 3.2.15) because participants did not receive adequate support from their supervisors after the training. To date, only the Biochemistry Department at the Teaching Hospital of JRA in Ampefiloha has sent a planning report (where they plan to train 25 medical biochemists). The Maternal and Child Health Department also committed itself to have its teachers apply the teaching methodology for teaching IMCNI starting in the 2007 academic year. Santénet will actively advocate with the dean of the medical schools to motivate and support faculty to implement their action plans.

RESULTS AND IMPACTS IN 2005 – 2006

Access to the Standards and Procedure document will assist providers in improving the quality of care. When the updated version is endorsed in 2006-2007, the reference document will be a rich source of information for providers about new health activities, i.e. the new FP methods (Implanon®, SDM, introduction of injectables at the community level), the new therapeutic protocol for malaria management (IPT and ACT), MTCTP, community-based use of zinc and Cotrimoxazole, and provision of post-abortion care by midwives. The document will be disseminated in 2007.

Another outstanding result is the institutionalization of PQI. The MOH/FP established a QAS unit as a result of Santénet's advocacy and the positive results from introduction of PQI at the 10 practicum sites. The coordination unit has incorporated PQI as part of the QAS approach, using the standards document as the evaluation tool for performance and quality. Santénet has worked closely with the unit to develop the QAS logo and to launch an IP program in hospitals throughout the country as well as to set up an IP certification system.

SDM was introduced and Santénet garnered government support for the method. With positive results from the pilot project, the GOM has decided to scale up its use throughout the country and Santénet succeeded in securing the support of other donors for training and procurement.

The involvement of community leaders, especially mayors and their teams, in the QAS process is beginning to yield tangible results (for instance in Bemenonga). In CBHCs, leaders proved to be highly motivated and were the first to commit themselves to improving the health centers.

CHAPTER SIX: INTERMEDIATE RESULT 4 (IR4)

IMPROVING THE INSTITUTIONAL CAPACITY TO IMPLEMENT AND EVALUATE HEALTH PROGRAMS

INTRODUCTION TO THE INTERMEDIATE RESULT

IR4 activities strengthen the health system and support civil society and NGOs in the implementation of health activities to promote family planning, improve child health, fight malaria, and prevent STIs, including HIV/AIDS. Improving institutional capacity improves collection and use of data for decision making (IR4.1), expands access to health information (IR4.2), improves the capacity of NGOs to implement health programs (IR4.3) and increases the capacity of the civil society to advocate for public health issues (IR4.4).

Improve data collection and use for decision-making (IR4.1). Madagascar's health information system traditionally focuses on statistics rather than surveillance data and is somewhat removed from disease control efforts. To complicate matters, there are multiple disease-tracking systems with differing reporting requirements and surveillance methods. Reporting procedures are inconsistent and quality of data is compromised as case definitions for many diseases are confusing or misunderstood. Detection and reporting of cases and epidemics is slow and largely ineffective. It is thus necessary to improve data collection and use by the Government of Madagascar for developing programs and/or adjusting activities to be more efficient, effective and responsive.

Expand access to health information (IR4.2). Decentralized public sector entities and NGOs often lack adequate information to plan, implement, and evaluate their efforts to improve health. Access to information empowers local authorities to improve their organization, management, and monitoring of health initiatives, and gives them evidence upon which they can better advocate for access to quality services and better prepare themselves to play a greater role in decentralized social service provision.

Improve the capacity of NGOs to implement health programs (IR4.3). NGOs operate networks of clinics and health centers across Madagascar that provide a substantial portion of the country's health care services. The GOM will continue to rely on NGOs to supplement the public health care system, making it imperative to strengthen NGO capacity to implement quality health programs. Furthermore, experience in Madagascar has shown that in addition to health organizations, non-health organizations (such as conservation, agriculture, women's and community groups) are well-positioned to effectively promote key health messages, provide referrals to the nearest health centers, and advocate for health services.

Increase the capacity of the civil society to advocate for public health issues (IR4.4). Civil society organizations, such as those mentioned above, need to build their capacity to advocate effectively on behalf of their constituents.

ACHIEVEMENTS 2005 – 2006

IMPROVING COLLECTION AND USE OF DATA FOR DECISION MAKING (IR 4.1)

AID IN THE UPDATE OF HMIS MANAGEMENT TOOLS (ACTIVITY 4.1.1)

An evaluation of district and national level MIS was finalized in the fourth quarter of 2004/ first semester of 2005. This process involved all of Santénet's programs and technical and financial partners. In 2005, meetings were organized to update current MIS tools and develop new ones. These tools were then approved and disseminated over the course of the year. All MIS tools were discussed during the working sessions of the MOH/FP's Annual Review in November 2005. As a result, the new framework for the Monthly Activity Report (MAR) tool for the CBHCs was formally endorsed. In addition, the session was an opportunity to educate the Regional Health Directorates, and secure their buy-in for the new MAR and to support its operationalization (i.e. production of the MAR, training, data collection, and transmission).

At the same time, GESIS, the computer software application needed for processing MARs, was updated at the DHFPS. The PARP project funded by the European Union financed GESIS installation and systems training, and Santénet provided technical and financial support to train MIS managers in 16 of 22 regional directorates — adding to the ranks of those already trained by the MOH/FP — as well as four remote District Health Services (of a possible 111) in GESIS. These on-site trainings took place in four waves allowing the trainers to work with the MIS managers on site to reduce costs and allow them to learn in the environment where the managers will work.

PARTICIPATE IN ESTABLISHING THE NATIONAL HMIS POLICY (ACTIVITY 4.1.2)

A diagnostic assessment of the Routine Health Information System (RHIS) in Madagascar conducted by USAID and the MOH/FP in late 2004 identified the need to integrate the Health Information System (HIS). In response, Santénet hosted a MIS workshop for all partners (e.g., the MOH/FP, EU etc.) in July 2005. As a result of this workshop, partners agreed to develop a national HIS strategy. Actions plans to implement the strategy will be discussed at meetings scheduled for November 2006.

REINFORCE THE CAPACITIES OF THE COMMUNES AND CBHCS TO EFFECTIVELY USE HEALTH DATA (ACTIVITY 4.1.3)

The RHIS assessment also noted that use of data remains one of the gaps in the system. Participants at all levels are not using the data collected by the health system. The design of a tool to help decision makers at all levels collect data and use it for decision-making (data for decision-making or DDM) has evolved through this process. Originally, wall sized graph – a chartbook - was envisioned . This would be placed at the CBHC to allow local leaders (CBHC head or Mayor) to make informed decisions . It was seen that this format could be used individually, or during group discussion. However, the prohibitive cost for producing this tool prompted Santénet

to rethink this strategy, deciding it was more beneficial to train CBHC heads in compiling data and in DDM, and shrinking the format of chartbook to a much smaller format but still allowing CBHC heads to share the information with the key players in their communes. Both DHFPS clinic and CBHC staff in KMs were trained in DDM, particularly using data collected in the MIS between November 2005 and May 2006. Santénet contributed to the design of the DDM curriculum. Santénet also implemented the training, attended by the heads of 155 CBHCs located in all 81 of Santenet's KMs, 29 district level MIS managers, and 10 MIS managers from the Regional Directorates.

After training, Santénet worked with Prospect International and the MOH/FP Health Statistics Unit, to assess the MIS performance for reliability, validity, completeness, timeliness, and use. A participatory methodology was developed that analysed MAR data received at the central level and conducted workshops that included DHFPS and Regional Directorate staff. Evaluation results showed that the percentage of CBHCs regularly sending MARs and meeting the criteria of accuracy, timeliness, and completeness increased from 14 percent in 2004 to 32 percent in 2006 following the training.

EXPANDING ACCESS TO HEALTH INFORMATION (IR 4.2)

SUPPORT SHARING OF HEALTH INFORMATION (ACTIVITY 4.2.1)

This activity aimed to work directly with MOH/FP to increase opportunities for information sharing and exchange, however, due to the lack of availability of program and ministry staff to act as counterparts, this activity was not accomplished. It is planned for the upcoming year.

IMPROVING NGO CAPACITY TO IMPLEMENT HEALTH PROGRAMS (IR 4.3)

HELP THE MOH/FP IMPLEMENT ACTIVITIES RELATED TO THE NATIONAL CONTRACTING POLICY FOR HEALTH (ACTIVITY 4.3.1)

Santénet and other MOH/FP partners supported the MOH/FP to develop and disseminate the National Contracting Policy. This policy aims to improve coordination and create standardized methods for monitoring health activities in Madagascar. A system of contracting creates harmonized performance standards and clarifies roles and responsibilities for all organizations implementing projects or clinics for the MOH/FP (for instance a CBHC run by SALFA). As a tool, contracting encourages health players to enter in to cooperation with each other, and creates uniformity of contract terms, such as reporting requirements and service costs.

After the National Contracting Policy was disseminated, Santénet provided technical and financial support to its implementation and use by: (i) establishing committees in charge of implementing the national contracting policy, including participation n the Monitoring Committee and Technical Committee, (ii) training 25 trainers from six regional directorates and several NGOs on contracting, (iii) developing and finalizing a contracting operations guide, (iv) developing a training module on contracting, and (v) training five regions in the Fianarantsoa province in contracting. Outside the regions, the training reached 25 DHFPS Fianarantsoa province and select health NGOs in the regional capitals.

SUPPORT THE FP PARTNERSHIP (ACTIVITY 4.3.2)

Our participation in and support to the Family Planning Partnership is described under activity 2.1.2.

FACILITATE PARTNERS' CAPACITY TO IMPLEMENT THE *KÔMININA MENDRIKA* APPROACH (ACTIVITY 4.3.3)

In April, Santénet hosted a mid-term workshop for partners to reflect upon achievements and accomplishments in the use of the KM approach. The workshop allowed the implementers to identify strengths as well as areas for improvement for KM's first cycle and to begin to consider implications for the next cycle. Achievements and results are described under activity 1.1.1 and in the M&E section.

HELP THE ES/NACC ORGANIZE THEMATIC WORKING GROUPS (ACTIVITY 4.3.4)

As part of the festivities marking World AIDS Day 2005 in Toamasina, 200 young people were targeted with messages on HIV prevention, screening, and psycho-social care of people living with HIV/AIDS (PLHAs). The celebrations included a bike race, a poetry competition, skits and videos, and exhibition booths staff by local AIDS service organizations, youth groups, and others to raise awareness and educate participants about HIV/AIDS.

MONITOR THE APPLICATION OF THE STI GUIDE (ACTIVITY 4.3.5)

The "Beyond Awareness Raising: A series of tools for participative for discussions on STI" guide is a tool created by the International HIV Alliance. Santenet has assisted by producing the guide for its partner NGOs and the ES/NACC to implement education activities on STI/AIDS. After disseminating the guide in four provinces to approximately 138 NGOs and associations in May, June and July 2006. Santénet hosted two participatory workshops to assess whether or not peer educators found the tool useful in June 2006. 25 participants attended those workshops. The workshop produced the following conclusions:

- Peer educators are using the guide, and find it easy to use. They have found that it helps facilitate sessions, provides easy-to-communicate messages, and inspires user confidence and satisfaction.
- Participants found that using the guide builds technical and facilitation capacities by providing them with concrete steps for facilitating an educational workshop and examples of activities. The steps encourage participation by all beneficiaries, by providing ice-breakers and transitions from general to specific topics.

Participants thought that the guide should include information on how to discuss STI prevention in an environment that discourages condom promotion or use. Furthermore, modules on HIV and STI testing should be integrated into the guide.

OTHER ACTIVITY COMPLETED

In collaboration with the MOH/FP, the regional directorates of Ihorombe and Atsimo-Andrefana, the DHFPS of Ihosy and Sakraha, Médecins du Monde, SALFA and the BAMEX project, Santénet organized and funded education and information activities specifically targeting sapphire miners in Ilakaka and Sakaraha. As part of the workshops organized by BAMEX to educate the miners on issues relating to natural resources and environmental management, Santénet mobilized resources and skills within the MOH/FP to discuss health problems that specifically affect the miners. Attended by 68 miners from Ilakaka and 93 in Sakaraha, these outreach activities covered issues such as HIV/AIDS prevention and management, tuberculosis, and bilharzias.

INCREASING CIVIL SOCIETY'S CAPACITY TO ADVOCATE FOR PUBLIC HEALTH ISSUES (IR 4.4)

ASSIST THE RELIGIOUS LEADERS' PLATFORM TO SUPPORT THE NEW FP AND HIV/AIDS STRATEGY (ACTIVITY 4.4.1)

The Religious Leaders Platform includes nine of Madagascar's major faith-based organizations who come together to promote the use of FP. Santénet assisted the platform in developing and submitting a concept paper to World Learning that requested funding for a three-year project to promote FP throughout the country. Awarded in May 2006, this grant is the first time that USAID/Washington has used the Flexible Fund account to fund a consortium of faith-based organizations to implement a project promoting the use of FP services. SAF/FJKM is the lead agency for the

project.

After the concept paper was approved, Santénet assisted the platform in organizing workshops for each individual group to plan and develop action plans, including budgets. In June 2006, the platform began its planned activities, developing a project implementation plan, training members in project management, training trainers, and collecting baseline data.

The platform's project incorporates two strategic pillars: promoting FP through traditional channels and in places of worship. Traditional channels used by the platform include IEC/BCC by community workers, improving availability of commodities and services through community workers and FP sites, and advocacy among civil and religious authorities at the local level. The second pillar utilizes platform member's places of worship and similar venues to promote FP. The faith-based organizations (FBOs) will specifically target the most remote and/or poorest families traditionally unable to access existing FP sources, use IEC tools to promote FP, include FP in their health centers, and expand existing community-based service delivery schemes.

In January 2006, the Platform of Religious Leaders was formalized under the name of PLeROC. Since its formalization, consultants have been recruited for TOT, a training curriculum has been developed and approved, and training of trainers have been implemented in six provinces. Over the three-year period of the project it should reach approximately 150,000 women of reproductive age in the 17 provinces where member organizations work. Currently, Santénet is continuing to provide technical support to PLeROC in finalizing a project document and producing IEC tools.

The FlexFund Project in Madagascar:
- Period: March 2006 –March 2009
- Location of activities year one: 17 communes and 128 fokontany in 5 provinces of Madagascar
- Total population to reached: 149,618
- FBOs: SAF/FJKM, SALFA, Balsama, Réseau traditionnel, Jejosy Mamonjy, EEM, and CSCMM

OTHER ACTIVITY COMPLETED

The MOH/FP and the ONN (Office of National Nutrition) updated *Profiles,* a tool to advocate for better nutrition, based on data and information taken from the different available surveys (DHS, MICS, etc.). The previous edition had been based on the 1997 DHS data, but this tool will now include data from the DHS III (2003-2004) and other recent surveys. Santénet and other partners collaborated in this effort, organizing three workshops with 20 participants in November 2006, with significant technical support from a consultant from Academy for Educational Development (AED). *Profiles 2005* was finalized at the end of the workshops.

Under the leadership of the ES/NACC, the National Strategic Plan for AIDS control and prevention for 2006-2012 was revised in collaboration with different donors and partners involved in AIDS control in Madagascar. Santénet was part of the working group dedicated to "Monitoring/Evaluation and Resources Mobilization". The final document was endorsed on October 17, 2006.

RESULTS AND IMPACTS IN 2005 – 2006

Improving health information collection and distribution is a critical piece of the puzzle in the effort to improve health in Madagascar. Improvements in data collection and transmission equip medical staff with information needed to provide appropriate and consistent care. Several activities have contributed to the improvement of data collection and available health information in Madagascar.

Data collection and use. Activities this year for promoting the collection and use of data repositioned MIS to the top of MOH/FP's priorities. The DHFPS and the regional directorates have demonstrated their support for the MIS by producing management tools based on a standardized model. In addition, the Health Statistics Unit demonstrated willingness to collaborate with Santénet by harmonizing its annual work plan with Santénet's, including supporting the implementation of the new MIS/MAR

system. Furthermore the MOH/FP has taken responsibility for MIS/MAR function and operations (with financial support from Santénet), the World Bank through the CRESAN project, the European Union, and the French Ministry for Cooperation. Buy-in and responsibility promote sustainability and use of the system. This demonstrates the increased capacity for collecting and analyzing data at the regional and district levels, and furthermore has led to a standardized mode of collecting data country wide.

The DDM training module designed, tested, and used for training heads of CBHCs on MIS has been proven as a model for establishing an MIS system. Other organizations have used the manual to train the CBHCs in their intervention zones, expanding the reach of the upgraded MIS system to locations and communes outside of Santenet's reach with no cost to the project.

Improving health information. The new materials and knowledge acquired through training activities allowed CBHCs, DHFPS, and regional directorate managers to improve activity management by using health information at their respective levels. As a result, the offices are better about planning and keeping their monitoring tools up-to-date, and units and programs are setting objectives based on accurate and relevant.
Training in MIS or GESIS has reduced production time for reports and new computer systems allow reports to be sent to the central level electronically. Data can now reach the central level in a more timely way: often the MAR reaches the central level in less than two months (as opposed to a full year, which was common before implementing the training).

Supporting health promotion in Madagascar. A national Contracting Policy will improve the way health projects are implemented locally by creating standard requirements and practices for organizations working health for the MOH/FP. The activities completed to date (developing the national policy, an operations guide and a training module, setting up implementation committees, training of trainers, and training ministry staff and local health organizations in five regions) have already led to standardizing a contracting system in Madagascar and have encouraged health organizations and the MOH/FP to cooperate. The national policy establishes a standard framework for partnerships within the Malagasy health sector, and clarifies the roles and responsibilities of actors. This applies to range of cooperative activities, from NGOs training CBDAs to pharmacies managed by CBHCs.

Santénet has supported NGOs and other organizations in health promotion this year, improving their capacity to address health issues. The "Beyond Awareness Raising" guide has been made available to partner NGOs in Madagascar's six provinces and has notably improved peer educators' interpersonal communication for HIV/AIDS control by improving the ability of organizations to educate their communities and providing a resource for implementing trainings.

Furthermore, through supporting PLeROC, different religious groups are now working together towards the same objective: promoting family planning. With Santénet's support, SAF/FJKM and the other members of the PLeROC, were awarded funding by the Flexible Fund, amounting to $438,000 for a three-year period (2006-2009). Santénet played a key role in mobilizing additional resources for the national FP program and encouraged private sector involvement in FP.

CHAPTER SEVEN

THE SANTÉNET FUND

ACHIEVEMENTS 2005 – 2006

The partners who entered into a contract with Santénet to implement the *Kaominina Mendrika* Initiative in June 2005 have now been carrying out the related activities for 14 of the 15 months provided by the agreement, the terms of reference, and the initiative's table of activities. The average distribution rate is between 70 and 80 percent for each subcontract and grant at the end of this reporting period. Ninety-five percent of each partner's total approved budget has been effectively spent.

During Cycle 1, the total of subcontracts and grants signed amounted US$856,000, which represents 42 percent of the US$2,000,000 that makes up the Santénet Fund.

A table summarizing the subcontracts and grants is presented on page 61.

In general, Santénet receives deliverables regularly and according to the table of activities. Some partners had difficulty keeping up with the monthly reporting schedule, which is mainly due to problems in collecting all supporting documents that go into the financial report. Similarly, some technical reports — the second deliverable under the contract — were not produced according to the agreed format or by the deadlines stipulated in the grants manual. Given this situation, Santénet conducted working sessions with the partners, especially those encountering difficulties, to remind them of the beneficiaries' obligations under the agreement, specifically using the standard format and keeping up with the reporting schedule. Santénet also assisted partners who encountered difficulties in submitting their financial reports.

During this period, several partners expressed their wish to have their implementation period extended to allow them to achieve results in the best working conditions. Therefore, Santénet amended the subcontracts and grant agreements in January 2006, extending the completion date to October 31, 2006 without any cost extension. All but two of our partners, chose to take advantage of this privilege. ADRA and CARE completed their deliverables within the initial timelines.

SIGNING CONTRACT DOCUMENTS

Upon USAID's approval, Santénet proceeded to sign new contract documents for implementing the Kaominina Mendrika approach in 27 new communes. These included one subcontract with CARE to work in eight new communes, and two grant agreements with new partner, PENSER Madagascar, to work in 19 new communes in July 2006.

Details are presented on page 61.

ACTIVITY MONITORING WITH VOAHARY SALAMA

Santénet requested increased involvement of Voahary Salama to allow for better monitoring of activities. The increased involvement was made concrete by increasing the time spent by Voahary Salama's staff assigned to the KM activities (Project coordinator, IEC officer, and monitoring officer) from 85 percent as stipulated in the initial grant agreement to 100 percent.

As a consequence, Voahary Salama's technical staff is now more available for the project and can better monitor field activities in collaboration with those KM partners that requested their technical assistance.

Preparing the final report

In preparing for the final financial report that partners will submit to Santénet at the end of the contract period in October, several working sessions were organized between the Santénet grants management team and the partners'

financial managers beginning in August. The goal of these working sessions was to enable grantees to understand all of the pieces necessary for preparing the final financial reports, in turn ensuring that Santénet receives the best information in a timely manner.

PREPARING THE SECOND CYCLE OF THE KM INITIATIVE

In July, Santénet sent out a Request For Applications (RFA)/Request For Proposals (RFP) to its current partners for the implementation of the KM approach new communes and to pursue activities in the current ones for a second year, applying an improved approach with a lower level of effort.

In addition to contacting its current partners, the project also sent out a RFA to new partners for implementing the approach in new communes. The new partners are PENSER, Linkajisy, and Zetra and were pre-selected based on their past experiences in community mobilization.

Since September, Santénet's Grants Committee comprised of the project director, the regional program coordinator, the financial and administrative director, and the subcontract and grant manager, have been reviewing proposals against the terms of reference of the KM's second cycle.

Out of the 17 applications/proposals expected, 15 have been received, two have been approved by USAID, two are going through the approval process at USAID, and 11 are being negotiated at the Grants Committee level.

SANTENET FUND TRACKER AS OF SEPTEMBER 30, 2006

CYCLE	Beneficiary	Code	Number of Communes	Names of the Communes	Date of signature	Total Amount Ariary	Disbursement to date Ariary	Remainder Ariary
CYCLE 1	**Sub-contracts**							
	CARE	CTR-001	10	Vohilengo, Ampasimbe Manantsatrana, Ampasina Maningory, Tsivangiana, Amboditavolo, Mahela, Betsizaraina, Ambodiharina, Tsaravinany, Masomeloka	3-Jun-2005	188,124,049.76	169,988,736.36	18,135,313.40
	CRS	CTR-002	8	Mahatsara Sud, Tsaravary, Andonabe, Anosimparihy, Kelilalina, Tsiatosika, Antsenavolo, Ifanadiana	14-Jun-2005	144,322,800.00	128,094,435.20	16,228,364.80
	ADRA	CTR-003	8	Anosibe An'ala, Belavabary, Amboasary, Ampasipotsy Gara, Anosibe Ifody, Vodiriana, Ambohidronono, Antanandava	13-Jun-2005	185,629,657.00	121,174,912.00	64,454,745.00
	CARE	CTR-004	1	Fort-Dauphin	25-Aug-2005	97,459,704.00	61,033,322.00	36,426,382.00
	Grants							
	ASOS CENTRAL	SPG-001	6	Brickaville, Mahatsara, Ranomafana, Ambila, Bemanonga, Mandoto	14-Jun-2005	141,082,800.00	94,838,580	46,244,220.00
	ASOS FORT DAUPHIN	SPG-002	8	Ifarantsa, Manambaro, Ankaramena, Ranopiso, Ankariera, Tanandava, Beheloka, Itampolo	14-Jun-2005	189,969,700.00	141,633,138.00	48,336,562.00
	SAF FJKM	SPG-003	8	Antentezambaro, Andasibe, Ambatovola, Beforona, Ilafy, Ambanitsena, Tsiafajavona, Marosoa	14-Jun-2005	183,513,236.00	106,652,887.35	76,860,348.65
	MATEZA	SPG-004	4	Manakambahiny Est, Antanandava, Ambodimangavalo, Amparihitsokatra	2-Aug-2005	99,583,380.00	52,087,068.00	47,496,312.00
	TANINTSIKA	SPG-005	3	Miarinarivo, Sendrisoa, Vohitsaoka	2-Aug-2005	77,490,900.00	42,818,588.67	34,672,311.33
	AINGA	SPG-006	4	Antaretra, Tsaratanàna, Ambohimiera, Ranomafana	2-Aug-2005	79,989,800.00	57,559,346.45	22,430,453.55
	MICET	SPG-007	2	Tolongoina, Ikongo	2-Aug-2005	48,678,250.00	41,359,352.50	7,318,897.50
	VOAHARY SALAMA	SPG-008		Technical assistance	2-Aug-2005	190,953,000.00	124,461,285.83	66,491,714.17
	SALFA	SPG-009	4	Sahambavy, Androy, Talatan'Ampano, Ambalakely	8-Aug-2005	103,247,604.00	63,091,728.00	40,155,876.00
	ASOS CENTRAL	SPG-010	4	Anivorano Est, Andranobolahy, Ambodilazana, Morarano Gara	30-Aug-2005	70,149,100.00	45,038,530.00	25,110,570.00
	SAF FJKM	SPG-011	1	Anjeva Gara	30-Sep-2005	26,175,444.00	8,257,610.09	17,917,833.91
CYCLE 2	**Sub-contracts**							
	CARE	CTR-006	8	Ampasimazava, Ambatoharanana, Soanierana Ivongo, Niherenana, Tanambao Mahatsara, Sahamatevina, Manjakandriana, Mahanoro	7-Jul-2006	215,619,926.40	43,123,985.28	172,495,941.12
	Grants							
	PENSER	SPG-012	9	Ialamarina, Fandrandava, Andranomiditra, Ihazoara, Vinanitelo, Ambatofotsy, Manampatrana, Ankazovelo, Midongy	26-Jul-2006	245,099,578.00	89,127,119.27	155,972,458.73
	PENSER	SPG-013	10	Mahasoabe, Andrainjato Est, Andoharanomaitso, Vohimarina, Ankarinarivo, Andrainjato Centre, Taindambo, Ivoamba, Ambalamahasoa, Mahatsinjony	14-Jul-2006	215,705,000.00	53,926,250.00	161,778,750.00

CHAPTER EIGHT

MONITORING AND EVALUATION

Monitoring and evaluation (M&E) is an important part of reviewing progress, tracking implementation, identifying problems, and making needed adjustments to ensure effectiveness, efficiency, and quality of activities. The monitoring and evaluation activities reported here focus on the results and impacts of the technical activities undertaken during this reporting period. We have also included a table which tracks Santénet's progress against the benchmarks set forth in the 2005-06 work plan and progress against the project's indicators and targets established in Santénet's revised Performance Monitoring Plan (PMP).

ACHIEVEMENTS AND IMPACTS 2005 – 2006

Implementation of the second year of Santenet's activities produced some impressive results and impacts. These are summarized in the table Objectives Monitoring Table on beginning on page 66. Some notable results of include:

INTERMEDIATE RESULT 1 (IR1)

KAOMININA MENDRIKA APPROACH

Significant improvements in health indicators have been made in the KM communes this reporting period. As of September 30, 2006, the MOH/FP and Santénet have awarded the *Kaomínina Mendrika* title to 25 of the 81 communes who had participated in Cycle 1 and had reached their health objectives. KM activities in these certified communes reached:

- A Total population of 348,253
- 80,098 women of reproductive age (23% of the total)
- 15,671 expected pregnancies (4.5% of total)
- 13,930 children between the ages of 0 – 11 months (4% of total)

Table 7 below presents the aggregated increases in basic health care coverage for the population in these communes.

Table 7: Increases in Basic Health Coverage in KMs

	Beginning of Cycle 1	*End of Cycle 1*	*MOH/FP national objective*
Contraceptive coverage rate	5.00%	11.00%	2.00% increase per year in order to reach 28.00% by 2009
First prenatal consultations	34.00%	73.31%	80% of pregnant women come for a first prenatal consultation
Tetanus inoculations for pregnant women	22.00%	117.63%	80% of pregnant women are vaccinated against tetanus
DTPHepB3	38.00%	88.41%	80% of children under one year are vaccinated against DTPHepB3

ANKOAY APPROACH

The Ankoay Scout approach proved to be a very useful way to reach youth in Madagascar with HIV prevention messages, and has the potential to reach more with the implantation of Ankoay Schools and Ankoay Sport.

Ankoay Scout: Between October 2005 and September 2006, 80 of 66 scout troops completed all activities and were certified as *Ankoay* Scout Troops. The 80 scout troops represent approximately 2,400 boy and girl scouts. As part of the *Ankoay* model, each scout is required to reach out to 10 non-scout youth, bringing the total number of youth reached by the first year of *Ankoay* to 24,000.

Ankoay Collège This module was initiated in 188 junior high schools, with approximately 5,500 students are directly involved.

Ankoay Sports: This module was initiated in 18 KM communes, with 144 soccer teams, representing about 3,100 players who will now be directly involved.

INTERMEDIATE RESULT 2 (IR2)

FP COMMODITIES AT THE DISTRICT LEVEL

During the past year family planning has been integrated into the GED, resulting in almost 100 percent of the DHFFS having placed accurate and effective orders for contraceptives commodities in Q4 2005 compared to only 56 percent in 2004, ensuring better availability at the district level of contraceptives.

Additionally, the 2006 FP logistics survey showed excellent results regarding the availability of contraceptive commodities in PhaGDis and service delivery points and with regards to an increase in consumption as recorded in the service registers. Percentage of Stock-outs of Depo-Provera decreased from 20percent to 13 percent in PhaGDis and from 18 percent to 4 percent in CBHCs between 2005 and 2006.

VACCINE MANAGEMENT IN MADAGASCAR

Santénet carried out a Vaccines Management Assessment using WHO/UNICEF methodology, providing a snapshot of the current situation at each level (central, intermediate, health facility) on the quality of management of vaccines, supplies, and the cold chain. Table 8, below, presents the comparison of 3 years results for the availability of vaccines, monitoring of vaccines and supplies stocks and reliability of the cold chain. Each indicator is measured on a scale of 0 to 5. All indicators of vaccines, supplies availability and cold chain reliability significantly improved from 2003 to 2006, indicating the effectiveness of Santénet's support to EPI and cold chain.

Table 8 : Comparison of Vaccine Availability between 2003, 2005 and 2006

	Year 2003			Year 2005			Year 2006		
	Central	Intermediate	Peripheral	Central	Intermediate	Peripheral	Central	Intermediate	Peripheral
Availability of vaccines	3.3	2.1	2.0	3.3	3.7	2.1	5.0	4.2	3.8
Monitoring of vaccines and supplies stocks	1.0	0.4	0.0	3.0	2.2	1.1	5.0	4.1	3.8
Reliability of the cold chain	2.5	2.4	2.4	2.5	3.5	3.2	3.0	3.1	3.4

CBDAS TRAINED AND SOCIAL MARKETING PRODUCTS SOLD

Since the implementation of KM approach, 1,820 CBDAs having been trained, representing a three-fold increase in the number of distribution agents that had been trained by PSI previously. These agents distributed thousands of social marketing projects within the 81 KMs between September 2005 and September 2006, as shown in Table 9.

Table 9: Social Marketing Products

Sales of social marketing products in the KMs (as of August 2006)		
Products	# of units	Increase over previous number of sales
SUR'EAU (bottle)	36,800	200%
PALUSTOP (Blister)	142,600	140%
PROTECTOR (unit)	114,000	400%
MII (unit)	119,700	1,370%
PILPLAN (tablet)	23,500	110%
Lo-Femenal (tablet)	20,200	260%*
Ody Tazo Moka (Blister)	28,200	unknown

HEALTH FINANCING SCHEMES IMPROVING ACCESS TO CARE

More than 13,000 people have received care by using the Equity Fund at the primary care level after just one year of implementation (July 2005 to June 2006). Furhtermore, mutuelles have increased in the use of outpatient consultation during the lean period (38% for the five pilots communes in Fianarantsoa II's DHS). This increase in coverage has further been improved by the scale up of mutuelles in the province of Fianarantsoa. In August 2006 the total number was increased to 87: 24 pilot sites, and 63 new sites. Nine trainers from the Regional Management teams and 67 managers from the District Management teams were trained on the promotion, implementation, and supervision of *mutuelles,* and will be able to assist in the scale up and implementation of the schems.

INTERMEDIATE RESULT 3 (IR3)

PQI IMPLEMENTATION

Two different approaches were used to introduce the PQI in rural CBHCs. In CHBCs where there are at least two or three staff members (40 of 147 CBHCs within all 81 KMs) external evaluations were conducted by trained evaluation team, needs were assessed and action plans were developed and implemented. In the 49 CBHCs that have only one or two staff members, providers self-evaluated their performance and develop their own action plan. In addition, a total of one hundred people were trained on the QAS methodology based on the QAS/PQI approach. At the end of each training workshop, province and evaluation teams created a plan to introduce PQI. Service providers were given IP refresher training in FP and STIs, and IP kits were distributed to them.

The 10 PQI practicum sites developed action plans for improving quality service provision. During this reporting period 80-95 percent of the action plans had been implemented. Additionally monitoring visits conducted in March 2006 in 10 practicum sites proved to be highly satisfactory. The sites achieved an average 67 percent of the standards in all three of the technical areas.

SDM INTRODUCTION

SDM method was introduced in 27 health centers in July 2005. After 10 months, 624 women adopted the method, among them 403 are new users and 221previously used another method.

INTERMEDIATE RESULT 4 (IR4)

UPDATE OF HMIS MANAGEMENT TOOLS

An evaluation of district and national level MIS was finalized, involving all of Santénet's programs, technical and financial partners. In 2005, meetings were organized to update current MIS tools and develop new ones. These tools were then approved and disseminated over the course of the year. As a result, the new framework for the MAR tool for the BHCs was formally endorsed. Santénet also provided technical and financial support to train MIS managers in 16 of 22 regional directorates as well as four remote District Health Services in GESIS software.

* over sales of Pilplan

HEALTH DATA USE

One hundred and fifty five CBHC heads BHCs located in all 81KM, 29 district level MIS managers, and 10 MIS managers from the Regional Directorates were trained in DDM, particularly using data collected in the MIS between November 2005 and May 2006. After training, SantéNet MIS performance was assessed for reliability, validity, completeness, timeliness, and use. Results showed that the percentage of BHCs regularly sending MARs and meeting the criteria of accuracy, timeliness, and completeness increased from 14 percent in 2004 to 32 percent in 2006 following the training

THE OBJECTIVES MONITORING TABLE

The following table presents project achievements in terms of indicators. The four columns in the left shows the activities as presented in Santénet 2005-2006 workplan, the objectives of each activity with a summary description, the progress made during the year compared to the objective set and the means of verification of this progress. The three columns in the right demonstrate how activities are linked to the Performance Indicators in Santénet's PMP. For each indicator, the defined benchmark for 2006 and the progress made towards benchmark are set out.

TABLE: PERFORMANCE TOWARDS OBJECTIVES SET FORTH IN THE ANNUAL WORKPLAN AND IN THE PERFORMANCE MONITORING PLAN

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR 1: Increasing Demand for Selected Health Services and Products						
IR 1.1 – Improving Community Mobilization and IEC/BCC for Selected Health Products and Services						
Activity 1.1.1 Provide assistance to partner NGOs in implementing Year 1 KM activities (81 communes)	***Objective:*** To complete Year 1 implementation of the KM approach in the 81 communes selected. ***Summary description:*** Santénet will organize one mid-term workshop in April 2006 to evaluate the activities and results achieved, share lessons learned and improve the technical framework of the KM approach. This workshop will also be used to determine the subsequent phase of the approach during cycle 2 for these 81 communes. In order to facilitate the NGOs' work, Santénet will also develop and implement a media plan to broadcast the audio material it has developed.. ***(*) Additional information:*** Santénet established a system of *tutoring* to strengthen the technical support and the follow-up of the implementing NGO in 81 Communes of cycle 1. The tutors will make at least of 3 follow-up visits during the cycle 100% of the communes involved in the KM approach	***KM monitoring system.*** - During quarters 2 and 3 of the reporting period, Santénet established a monitoring system utilizing different monitoring tools and mechanisms. In doing this, Santénet set up a mentorship system As a result, Santénet and Voahary Salama visited all 81 communes at least once during the reporting period. - Santénet, with assistance from Training Resources Group (TRG), also held a midterm KM workshop in April 2006. More than 100 participants attend this workshop ***KM mass media program*** - In December 2005, the project established terms of collaboration with 60 radio stations for airing the mass media kit (a compilation of spots and stories– see Activity 1.1.6 for more detail) 49 KM communes (60%) are currently in the listening areas of these radio stations	Mid-term workshop held Workshop report Monitoring report KM Monitoring questionnaire	***PMP indicator #6*** Number of communes that achieve Champion Commune status for achievement of health targets	64 communes from 2005 reaching 1st level of KM status and involved in next step 211 New communes in which KM approach will be introduced [This objective was revised because activities will be conducted in two phases of 18 months instead of 3 phases of 12 months]	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	will be covered by the media through proximity radio stations.					
Activity 1.1.2 Develop and test a new model for implementing KM	***Objective***: To ensure the sustainability of the KM approach. ***Summary description:*** Santénet will review the technical and financial aspects of the approach. Upon this review, Santénet will develop an improved model and finance certain partners to pilot this new model in selected communes during the Year 2 implementation of KM. Santénet will also review the various KM tools and revise them based on the new model. ***(*) Additional information:*** An improved model will be developed in order to reduce of at least 10 % the cost and simplify the different stages. This model will be implemented in 211 New communes of the cycle 2.	**-** Reducing the original ten step model to seven steps to better incorporates commune structures and the working environment, and more effectively involve the MoH/FP's decentralized structures. - Reducing by one-third the cost of the first year of implementation *- Requiring a mere 30% of the first year's implementation budget to implement a second year in Cycle 1 communes* *- Selecting sites that are in close proximity to successful KM will allow for cost-sharing.*	Streamlined cost-effective KM model developed and implemented in selected pilot communes	***PMP indicator #6*** Number of communes that achieve Champion Commune status for achievement of health targets	64 communes from 2005 reaching 1st level of KM status and involved in next step 211 New communes in which KM approach will be introduced	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.
Activity 1.1.3 Begin implementing Year 2 KM activities	***Objective:*** To scale-up the KM approach**.** ***Summary description*** : Santénet will continue working with the partner NGOs of Year 1 to define new objectives for Year 2 and ensure continued success in the 81 communes. Santénet will utilize the Santénet Fund to award a second round of contracts and	***KM Cycle 2 grants and sub-contracts*** - In July, Santénet renewed the CARE sub-contract, allowing them to begin implementing *Kaominina Mendrika* in eight new communes in the Toamasina Province, while completing the certification process in the ten Cycle 1 communes. - Santénet initiated discussions with two new partner NGOs, PENSER and		***PMP indicator #6*** Number of communes that achieve Champion Commune status for achievement of health targets	64 communes from 2005 reaching 1st level of KM status and involved in next step 211 New communes in which KM approach will be introduced	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	grants, anticipating that current partners, along with new ones, will scale up the KM approach during the second year. ***(*) Additional information:*** After revision of its scaling-up strategy of KM, Santénet anticipates that current partners, along with new ones, will expand KM approach during the cycle 2 to reach 211 New communes. KM approach will be implemented in 300 communes (81 communes cycle 1 and 211 New communes)	LINKAJISY, and with different RHPPD and DHFPS regarding *Distrika Mendrika* (DM). - Santénet also awarded two grants to PENSER, one to implement KM in ten new communes, and the other to implement FP and KM activities in nine remote "Extra Mile" communes. ***Implementation in 211 new communes:*** This objective was revised because activities will be conducted in two phases of 18 months instead of 3 phases of 12 months				reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.
Activity 1.1.4 Pilot the Tanàna Mendrika (TM) approach in Fort Dauphin	***Objective:*** To develop an urban community mobilization approach. ***Summary description :*** Santénet will work with CARE to test an urban community mobilization approach similar to that of Kôminina Mendrika, but which takes into account the urban setting. Santénet will then negotiate with CARE to implement the approach in Fort Dauphin. Santénet will provide technical assistance, including training the key actors involved in implementing the approach, and providing the necessary IEC/BCC tools.	- Santénet trained five CARE staff as IEC/BCC trainers and supported the same training of CBDA Trainers by PSI. - CARE's staff then trained 64 IEC/BCC outreach workers, 62 of which were also trained as CBDA.	TM approach implemented in Fort Dauphin.	***PMP indicator #6*** Number of communes that achieve Santénet Champion Commune status	64 communes from 2005 reaching 1st level of KM status and involved in next step 219 New communes in which KM approach will be introduced	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
						end of this reporting period.
Activity 1.1.5 Assist IECSMU in making the HCMC fully operational	***Objective:*** To strengthen IECSMU's leadership role in all IEC/BCC and social mobilization activities. ***Summary description:*** Santénet has been designated secretary of the HCMC, and will provide technical assistance to IECSMU to make the committee fully operational. More specifically, Santénet will assist IECSMU in organizing the committee's general assemblies and sub-committee meetings, based on a pre-established calendar, and in effectively leading those meetings. Santénet will also participate in the technical validation of partner IEC/BCC materials. ***(*) Additional information:*** 2 committee's general assemblies and 4 sub-committee meetings will be organized with the MOH/FP	- ***General assemblies of the IECSMC.*** **-** The IECSM organized two general assemblies of Health Communication and Mobilization Committee (NHCMC): first assembly in October 2005 and second assembly in April 2006 - One meeting of the Family Health sub-committee was held in February 2006. - Regular meetings of the other sub-committees were replaced by meetings to revise the message guide with the IECSMU in May, 2006.	Meeting reports	***PMP indicator #7*** Availability of IEC/BCC minimum package at CBHC level	60% of CBHC in Santénet target areas (ex-provinces of Antananarivo, Fianarantsoa, Toamasina, Toliary) have the minimum package of IEC/BCC materials available	This benchmark was not reached because an integral part of the package, the message guide, is currently being revised the MOH/FP and its partners.
Activity 1.1.6 Contribute to the HCMC's activities (as described in its TOR)	***Objective:*** To contribute to a better collaboration and coordination between MOH/FP and its partners of IEC/BCC and social mobilization activities. ***Summary description :*** Santénet will participate in the update of the Messages Guide,	The minimum package is not currently available in 60% of CBHCs, because the message guide, an integral peice of hte package, is not yet available. It is currently being revised by the MOPH/FP and its partners Because of the high cost of producing the minimum IEC/BCC package, the IECSMU suggests presenting the	Messages Guide updated Minimum package of IEC/BCC health materials defined and shared	***PMP indicator #7*** Availability of IEC/BCC minimum package at CBHC level	60% of CBHC in Santénet target areas (ex-provinces of Antananarivo, Fianarantsoa, Toamasina, Toliary) have the minimum package of IEC/BCC materials available	This benchmark was not reached because an integral part of the package, the message guide, is currently being revised the MOH/FP and its

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	define a minimum package of IEC/BCC health materials, develop a dissemination plan for the minimum package, and ensure that the package is available in all the health centers located in its KM communes. Santénet will also contribute technically and financially to IEC/BCC activities related to international celebrations (World Health Day, World AIDS Day and others) and to national campaigns. ***(*) Additional information*** Santénet will ensure the minimum package available in 60% of Health centers in the 4 provinces of intervention and in all CBHCs in the KM Communes.	package in the form of a catalogue.				partners.

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 1.1.7 Contribute, as a member of the Family Health sub-committee, to the development and implementation of the FP communication strategy	***Objective:*** To develop an FP National Communication Strategy that responds to the new FP National Strategy priorities. ***Summary description:*** Santénet will contribute financially to the FP strategy's development, as well as assist FHD and IECSMU in securing financial support from the other members of the sub-committee for the other steps. *Once the strategy is developed and validated, Santénet will contribute technically and financially to the development and production of IEC/BCC materials, including components defined as part of the IEC/BCC minimum package. Santénet will also make certain that the communication strategy is distributed to the Flex Fund-funded religious organizations in order to make sure that they consider it when developing and implementing their FP activities.* ***(*) Additional information*** This year, Santénet will: - Provide financial support to FP messages mediatization through 65 radios, with 2 spots a day during 15 days a month over a period of 4 months. - Provide technical support to the MOH/FP to develop the FP communications	***FP communication strategy.*** During the reporting period, Santénet provided support to the MOH/FP's Reproductive Health and Safe Motherhood Unit (RH/SMU) in preparing its FP communication strategy: - Six regional workshops; were organized . Santénet funded four of six and co-facilitated the Toamasina and Fianarantsoa workshops with the MOHFP team. - In Q3 and Q4, Santénet assisted RH/SMU in preparing the strategy's first draft that was distributed to all FP partners for feedback. - It is scheduled that the strategy will be finalized and approved in October 2006. ***FP media campaign*** - 48/65 partner radio stations of Santénet aired 2 spots a day for 4 months between the period March to July 2006, according to a specific media plan	FP communication strategy developed and validated Rapport de diffusion	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	strategy - Contribute financially in the diffusion of the document of strategy					

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	(*) Additional information This year, Santénet will: - Provide financial support to FP messages broadcast through 65 radios, with 2 spots a day during 15 days a month over a period of 4 months. - Provide technical support to the MOH/FP to develop the FP communications strategy - Contribute financially in the diffusion of the document of strategy	- In Q2, Santénet assisted the unit in identifying the FP communication strategy's main components based on the results of several UNFPA-funded social and cultural research studies on RH/FP				
Activity 1.1.8 Study the feasibility of establishing Child Health Week in Madagascar	***Objective:*** To establish Child Health Week (CHW) in Madagascar. ***Summary description:*** Santénet will develop a concept paper for the possible establishment of this approach in Madagascar. This concept paper will serve as a basis for discussion with the MOH/FP and other important partners such as UNICEF. Santénet will play an active role in facilitating the dialogue between the various partners and in collecting	- During Q2, Santénet held a meeting with the MOH/FP to present a concept paper on introducing a Child Health Week in Madagascar. The Ministry approved the initiative and officially announced at the Senior Inter-Agency Coordination Committee's meeting in June 2006 that the Vitamin A and deworming campaigns usually held in April and October would be replaced by Child Health Weeks, .	Technical document developed and validated by MOH/FP	***PMP indicator #2*** DPT 3 coverage	65.3%	69.3%
				PMP indicator #3 Vitamin A supplementation coverage	79%	85%
				PMP indicator #5 Exclusive breastfeeding rate	67%	70%
Activity 1.1.9 Assist MOH/FP in organizing the first Child Health Week	***Objective:*** To establish Child Health Week in Madagascar. ***Summary description :*** Based on the results of the feasibility study mentioned above, Santénet, in collaboration with UNICEF and other health	- The first will be celebrated the week of October 23, 2006 - Santénet will continue to provide support to the Ministry during the month of October, and will act as the logistical focal point for the launch in Mahajanga. - Les résultats de la campagne ne sont	The first Child Health Week is held	***PMP indicator #2*** DPT 3 coverage	65.3%	69.3%
				PMP indicator #3 Vitamin A supplementation coverage	79%	85%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	partners, will assist MOH/FP in organizing the first Child Health Week. In the communes where the KM approach is being implemented, Santénet will make sure to mobilize households with children during the Child Health Week through different awareness-raising activities. ***(*) Additional information*** If the feasibility study is decisive, the first CHW week is planned in October 2006. This coincides with the week of Vitamin A. 95 % of the children under-5 will be covered at least by an activity for this week of health of the child.	pas encore disponible.		***PMP indicator #5*** Exclusive breastfeeding rate	67%	70%
Activity 1.1.10 Contribute to ES/NACC's activity of training 150 radio hosts	***Objective:*** Strengthen IEC/BCC on HIV/AIDS and other health issues through the radio. ***Summary description:*** Santénet will provide assistance to ES/NACC in distributing 300 hand crank radios throughout the country, especially in remote areas, and will then provide financial assistance in training 150 radio hosts. ***(*) Additional information:*** Radio production technique will be the main topic of the training	In the 2005 workplan, Santénet was to carry out this activity after Concorde submitted a monitoring and evaluation report on the training it provided to radio stations and to use the trained radio stations to produce and air IEC/BCC materials in the KMs. The report has yet to be completed; therefore Santénet decided to replace the activity with Activity 1.2.2.	150 radio hosts are trained			

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 1.1.11 Provide assistance to the implementation of the Ankoay project, Phase I	***Objective:*** To reinforce youth mobilization for HIV/AIDS prevention. ***Summary description:*** HCP submitted a proposal to PMPS to receive funds to implement Phase II of the Ankoay project, which will scale up the Ankoay approach to an additional 200 scout troops and adapt the approach to be used in schools and sports clubs. Because PMPS II funds will not be available until 2006, Santénet will provide bridging funds to ensure that the Ankoay project's activities are not interrupted.	***Activities with the scout troops*** ***1-*** Santénet and HCP expanded the pool of Ankoay Scout trainers with a second series of trainings of trainers in April 2006. As a result: . 30 new trainers of trainers were trained, and began training troops in other regions; . 61 new scout troops or more than 2,000 scouts, have been trained since December 2005. ***Expanding the Ankoay approach to junior high schools.*** In 2006, the Ankoay program was extended to schools, mainly junior high schools, in an effort to reach youth that do not participate in scouting. - Thirty trainers of trainers from the HIV control unit at the Ministry of Education were trained in June 2006. - Throughout Q4, instructors from the eight educational administrative areas were trained for the Ankoay Collège program. The instructors will be in charge of training 6 pupils in each school, totalling 240 students trained. In all, 600 Ankoay Collège kits were distributed during the training activities.	Ankoay project Phase II activities are implemented	***PMP indicator #4*** Condom use at last sexual encounter with a paying partner, among youth and commercial sex workers	Men 15-24 = 30%	Waiting for DHS data
					CSW = 80%	Waiting for DHS data
					Women 15-24 = 24%	Waiting for DHS data
Activity 1.1.12 Implement an Ankoay II project	***Objective:*** To reinforce youth mobilization for HIV/AIDS	Ankoay's expansion will also target young people in rural areas, especially sportspeople in Santénet's KMs,	Ankoay II project started	***PMP indicator #4*** Condom use at last sexual	Men 15-24 = 30%	Waiting for DHS data

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
targeted for young sportsmen and sportswomen ◘	prevention. ***Description:*** Santénet will provide technical assistance for the start-up of a project with an approach similar to that of the Ankoay project, but is specifically targeted towards young sportsmen and sportswomen instead of scouts. ***(*) Additional information*** The local partners for « Sports for life » will be the Sports Clubs in the communes. Santénet will closely work to implement the activities with the Delegation of the Ministry of Youth and Sport at the district level.	expanding the reach of the initiative to even more youth. - In 2006, the approach was implemented in 18 KM and has reached on average eight football l clubs with 30 to 40 young people per commune. - An Ankoay Scout leader was recruited as a consultant to provide assistance in adapting the training model to the needs of sports clubs, - Two clubs, AJESAIA, and the EPNFC from private school Nirina, participated in the launch of the Ankoay sport program in July 2006., reaching an audience of approximately 1,000. - A series of trainings for coaches and KM supervisors from partner NGOs in 18 KMs were organized in the provinces of Fianarantsoa, Toliara, and Toamasina, in August and September 2006, training 84 sport coaches in Ankoay methods. The coaches will train eight clubs of approximately 30 players per commune and will monitor and assess the teams. Furthermore, they will organize intra- and inter-commune Ankoay.		encounter with a paying partner, among youth and commercial sex workers 40% 85%	CSW = 80% Women 15-24 = 24%	Waiting for DHS data Waiting for DHS data
IR 1.2 – Increasing Private Sector Involvement in Promoting Health Services and Products						

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 1.2.1 Strengthen IEC/BCC capacities of KM partner NGOs' Community-based Distribution Agents (CBDAs)	***Objective:*** To train new CBDAs in IEC/BCC while expanding the distribution network for social marketing products. ***Summary description***: Santénet will continue providing technical and financial assistance to PSI in preparing and, in some cases, holding the training of trainers sessions. When deemed necessary, Santénet will also provide or duplicate IEC/BCC materials. These training sessions are directed to the CBDAs of the current KM partner NGOs, and will also be offered to new KM partner NGOs during KM cycle 2. ***(*) Additional information:*** Santénet intends to train 2 Assistant Technicians (TA) for each commune in IEC/BCC for Social Marketing in the 211 New communes, i.e. a total of 438 TA. Each TA will then train 20 CBDAs per commune, i.e. a total of 4 380 CBDAs for all the communes involved in KM cycle 2	This objective was not reached because Cycle 2 has not yet began in many communes and most existing communes are currently finishing Cycle 1.	CBDAs trained and necessary IEC/BCC material available	***PMP indicator #11*** Santénet KM have an established distribution system for social marketing products	64 KM from 2005 have an established distribution chain for Social Marketing products	81 KM have established distribution of Social Marketing products.
					# CBDAs trained in Cycle 2 KMs [To be revised because activities will be conducted in two phases of 18 months instead of 3 phases of 12 months]	Cycle 2 has not been established yet
Activity 1.2.2 Develop partnerships with private radio stations to help implementing KM activities	***Objective:*** To involve mass media to promote the KM approach and communicate key health messages. ***Description:*** Santénet will work with the radio stations	- Santénet would train local radio stations in radio production in exchange for a commitment from each to air ten KM spots per day, and two sketches and one tale per month for free.	Plan of broadcasting radio KM montoriring questionnaire	***PMP indicator #6*** Number of communes that achieve Santénet Champion Commune status	64 communes from 2005 reaching 1st level of KM status and involved in next step 211 New communes in which KM	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	involved in the "Radio Corridor" USAID Eco-regional Alliance initiative and will negotiate with those private radio stations to air those spots, sketches and children's tales for free on a regular basis. In exchange, Santénet will train radio show hosts and producers of those stations in radio show production and broadcasting, especially in the context of health. ***(*) Additional information:*** This activity is aimed at ensuring the media coverage of 81 and 211 New communes. Every radio will disseminate at least: 5 spots a day, 2 sketches and 1 tale per month.	- 49/81 (60%) KM cycle 1 in Santénet's four intervention provinces, are covered by the partner radio stations			approach will be introduced [To be revised because activities will be conducted in two phases of 18 months instead of 3 phases of 12 months]	months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.
Activity 1.2.3 Contribute to the IEC/BCC component of the Workplace Initiatives	***Objective:*** To involve private businesses in the promotion of better health. ***Summary description*** : Santénet will develop the Orinasa Mendrika (Champion Business) approach which will require Santénet and the businesses to define IEC/BCC activities that contribute to the achievement of the KM objectives. The IR2 team will set up workplace initiatives (e.g. activity 2.2.1), and the IR1 will then provide technical assistance for the development and implementation of the IEC/BCC component. The IR1 team will also provide all the	After some unfruitful discussions with company managers, Santénet turned its efforts to target the informal sector. - In July/August 2006 Santénet, in collaboration with PSI, the MCH clinic of Tsaralalana and the CBHC of Isotry, trained seventy hairdressers from the poor neighborhoods of Antananarivo in infection prevention and HIV education.	Private businesses with workplace initiatives that implement specific IEC/BCC activities	No specific PMP indicator is directly linked to this activity. However, it will strengthen the overall performance of our programs		

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	IEC/BCC material necessary ***(*) Additional information:*** For this year, Santénet will introduce the different stages of the implementation of the approach in association with PSI in 7 companies among which 4 are situated in the communes involved in the KM approach and 3 companies outside KM.					
IR 1.3 – Increasing Demand for FP and Health Services and Products in Priority Conservation Areas						
Activity 1.3.1 Assist ERI in the implementation of the integrated Health-Environment KM approach	***Objective:*** To increase the number of communes located in priority biodiversity conservation areas implementing the KM approach. ***Summary description:*** Santénet will work closely with the USAID-funded ERI environmental project to implement the integrated Health-Environment KM approach. Among the 81 communes for KM cycle 1, 5 communes were selected in the province of Toamasina where the integrated approach will be implemented, and 6 other communes will be selected in Fianarantsoa province. Santénet will provide additional technical assistance to ERI in the process of defining environmental objectives, developing the tools for implementation, and training community outreach workers in IEC/BCC	The objective was not met because of the 11 communes referenced, most are still finishing Cycle 1. Only two communes in Fianarantsoa were certified as health and environment KMs in September 2006. The other communes are at the evaluation stage, anticipating certification in October 2006.	Integrated Health-Environment KM approach is implemented	***PMP indicator #8*** Number of communes in priority biodiversity conservation areas that achieve Champion Commune status	10	2 Due to the extension, 9 are expected to be certified in October

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	techniques. ***(*) Additional information:*** During the cycle 2, we anticipate 11 new Communes will implement the Health / Environment integrated approach					

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR 2: Increasing Availability of Selected Health Products and Services						
IR 2.1 – Improving the Logistics System for the Public Sector						
Activity 2.1.1 Support the logistic system for contraceptive products by improving integration with generic	***Objective:*** Ensure the sustained availability of contraceptive products at FP sites. ***Description:*** Santénet will	- In April 2006 new parameters were established for maximum stocking requests, converting the distribution system to a "pull" rather than a "push" system	Document of evaluation of the integration of the contraceptive products Reports from meeting	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
essential drugs	support the Family Health Division (FHD) to identify the problems and to harmonize the procurement of FP products. Santénet will also sponsor workshops on problem identification, training of trainers as well as other trainings at the regional and medical district level. Moreover, Santénet will support the FHD to carry out quarterly evaluations of the integration of contraceptive products to ensure better monitoring on user access and availability.	- In Q2 of 2006, a computerized tool for contraceptive commodities management and data analysis was design and put in place in collaboration with the RH/SMU team - Preparing monthly reviews of contraceptive supplies and organizing the annual RH/FP coordination meetings in order to identify problems in the supply chain and logistics management systems, and to define strategies for solving problems encountered - Monitoring the implementation of recommendations that came out of the FP partners meetings. The data needed to estimate contraceptives needs are now available and have been forecasted through 2012		***PMP indicator #9*** Reduction in the number of stockouts of injectable contraceptives at the CBHC level (a 2% annual reduction)	10%	4%
Activity 2.1.2 Support the MOH/FP in the procurement of contraceptive products	***Objective:*** To have adequate stock levels across the entire supply chain to meet national needs ***Summary description:*** Santénet will support the MOH/FP, through the FHD, in contraceptive product procurement, specifically in support to forecasting and monitoring stocks and orders ***(*) Additional information*** Activities include support to quarterly monitoring, use of monthly reports, forecasting and annual procurement plan	- Santénet supports the RH/SMU in the forecasting activities twice a year, to facilitate the increase in funding. - Procurement plans for 2006, 2007, and 2008 were developed and approved by partners, securing adequate funds for the next two years. - Plans for financing 2008 needs will be finalized in Q4 of 2006. - An assessment workshop to review the contraceptive security situation vis-à-vis supply chains, institutional frameworks, access to FP products and services, use of contraceptives, and resources and funding, was organized.	Availability of planned stocks based on forecasted demand	***PMP indicator #9*** Reduction in the number of stockouts of injectable contraceptives at the CBHC level (a 2% annual reduction)	10%	4%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	**Benchmark 2006**	**Progress towards benchmark**
Activity 2.1.3. Support the establishment of new FP sites in health centers	***Objective:*** To make FP services available to all target populations through health centers ***Summary description:*** Santénet will support the FHD and the MOH/FP to conduct a study to determine the necessary technical and supervisory skills needed at the facility level ***(*) Additional information*** 2 training sessions for health care providers and for responsibles at the District level in the 4 provinces of intervention of Santénet will be organized this year	Santénet provides timely technical support the activity upon the RH/SMU unit's requests. Santenet is helping plan and monitor the implementation of the FP site extension strategy. Between October 2005 and July 1006, 104 new FP sites became operational. The training activities defined in this objective were acheived by the RH/SMU without Santénet's support	New FP sites established Evaluation report	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.1.4. Support to the implementation of Reach Every District (RED) for EPI	***Objective:*** Reinforce technical operations and evaluation capacity for routine immunization (3HépB3). ***Summary description:*** Santénet will continue to support the Immunization Service at the district level, providing training and supervision of activities which will improve data analysis and promote the systematic utilization of data for decision making at a local level. ***(*) Additional information*** Santénet will support this activity in 2 Districts in Toliara and Toamasina	- In December 2005: providing technical and financial support to the MOH/FP in introducing and implementing RRI to 3Hép3 and reinforcement of the Reach Every District (RED) approach in 2 regions (Atsinanana and Haute-Matsiatra - Supporting routine EPI activities and improved immunization coverage in 111 health districts through regional and district level management training for health workers.: 55 health workers trained in Middle Level Management (MLM) for EPI, 18 people from the Haute-Matsiatra region trained in Data Quality Control (DQD), and 133 people from eight regions trained in the use of computerized management tools. - Preparing meetings for the external assessment of Data Quality Control., in data collection missions, and in the validation of the external assessment results	Reduction in drop-out rates for EPI Monthly data evaluation reports	***PMP indicator #2*** DPT 3 coverage	65.3%	73%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.1.5 Ensure the proper function of the cold chain for EPI	***Objective:*** To reinforce the logistics system and the cold chain management for the National Immunization Program. ***Summary description:*** Santénet will ensure technical and financial assistance for training and supervision of district-level cold chain managers in KM communes. ***(*) Additional information*** Santénet will financially support MOH/FP central team from the Immunization Service to conduct the National evaluation of EPI Logistics and to supervise the health centers	- In October 2005, collaboration with the IACC logistics subcommittee to improve supply chain coordination by conducting . survey on EPI logistics . Vaccine Management Assessment . assessment of the cold chain performance in six regions in 2005 . Monitoring the implementation of recommendations - Develop an EPI logistics reference manual for Madagascar and job aids for BHC health workers	Assessment report	***PMP indicator #10*** Functional cold chain at the CBHC level	In 63% of CBHCs Temperature monitored daily and in the range of +2°C and +8°C.during last 6 months The stock of vaccine sufficient until the next supply scheduled by the district level arrives	75%
Activity 2.1.6	***Objective:*** To improve data	- Training regional and district-level	- Immunization coverage	***PMP indicator #2***	65.3%	73%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Support EPI data management through the use of computerized management tools	quality. ***Summary description :*** Santénet will provide technical and financial support through the installation of data processing software and the training of RHD and MOH/DHFPS data analysts ***(*) Additional information*** 18 RHD data analysts and MOH/DHFPS in 6 regions of Toliara and Toamasina provinces will be trained this year.	managers from 15 Regional Directorates and 75 DHFPS.in the use of self-assessment tools for EPI DQC and the use of the computerized tool for managing vaccines, information, and the cold chain	of health districts as planned - MOH/FP's annual work plan; - installation of software	DPT 3 coverage		
Activity 2.1.7 Ensure adequate supervision of operations for the EPI program	***Objective:*** To collaborate in the installation of the MIS to improve data-for-decision making and effective epidemiological monitoring in targeted sites ***Summary description***: Supervisory activities ensure regular supplies of vaccines and consumables, improved quality of service, and effective epidemiologic monitoring to eliminate tetanus, control measles and eradicate polio. ***(*) Additional information*** Santénet will lead formative supervisions in 6 low performance districts in 6 regions of Toliara and Toamasina.	- In August 2006, took part in the MOH/FP's initiative to review EPI - Polio vaccination campaign in October 2005 in one DHFPS of Ihorombe (Lakora) and four DHFPS of Atsimo-Andrefana ((Midongy, Ampanihy, Farafangana, Vagaindrano): Provided technical and financial assistance for formative supervision activities during the Polio vaccination campaign in October 2005 for regions of Haute Matsiatra, Vatovavy Fitovinany, Vakinankaratra, Analamanga, Bongolava, and Itasy regions: 92 trainers and 20 supervisors were trained	Assessment report	***PMP indicator #2*** DPT 3 coverage	65.3%	73%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.1.8 Participate in national vitamin A and deworming campaigns	***Objective:*** To contribute to the fight against vitamin A in children under five. ***Summary description :*** IR2 will provide technical and logistical help to ensure the availability of products and services, complementing IR1's financial and technical support to community mobilization activities ***(*) Additional information*** Santénet will support the campaings in 4 provinces of intervention for the organization of 2 microplanification workshops in 2 regions and for the supervision of the campaigns by the MOH/FP central staff in 6 regions	Provide technical and financial support to the vitamin A distribution in Atsimo Andrefana, Atsimo Atsinanana, and Ihorombe regions in 2005 and 2006		***PMP indicator #3*** Vitamin A supplementation coverage (targeted increments of 3% per year)	79%	85%
Activity 2.1.9 Provide logistical support to the MOH/FP and partners to introduce the new malaria treatment protocol	***Objective:*** To facilitate the introduction of new malaria treatment. ***Summary description:*** Santénet will support targeted health districts, in terms of logistics, monitoring and supervision of activities, in collaboration with the SNLP. ***(*) Additional information*** Santénet will support 2 health districts, in terms of logistics, monitoring and supervision of activities, in collaboration with the SNLP	Support the MOH/FP to introduce the new Artemisinin-based Combination Therapy (ACT), in planning, coordinating activities, and gradual introduction. The expected results were not reached ACT has not yet been made available during this reporting period.	Plan to introduce new treatment protocol implemented	No specific PMP indicator is directly linked to this activity. However, it will strengthen the overall performance of our programs		

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.1.10 Support the distribution of ITNs for pregnant women and children under five through the public health system	***Objective:*** To prevent malaria in pregnant women and children under five. ***Summary description:*** Santénet will contribute to ITN distribution at a logistics level to ensure product availability, for ITNs and other products related to malaria prevention (e.g., reimpregnation kits), based on MOH/FP policies and needs, and will assist in the evaluation of activity indicators. ***(*) Additional information*** Santénet will help strengthen the distribution system of ITNs and the monitoring process at the central level	Santénet's support for the distribution system was no longer required. From January to August 2006, the Malaria Control Unit distributed 575,000 ITNs (acquired with funding from the Global Fund's fourth round) in 31 priority DHFPS where malaria is endemic.	ITN distributed through the public health system	No specific PMP indicator is directly linked to this activity. However, it will strengthen the overall performance of our programs		
Activity 2.1.11 Support the implementation of the condom programming strategy	***Objective:*** To support the fight against HIV/AIDS/STI. ***Summary description:*** Santénet will continue to furnish technical support to operationalize the distribution plan and to ensure consistent communication amongst the players in condom programming.	Provide technical support to the manager of the condom distribution based on recommendations made by two consultants the project recruited. For example, identifying new points of sale for private sector brand condoms to increase their availability and use on taxi-buses. .	Functioning of the public sector condom procurement system (FIMAILO)	***PMP indicator #4*** Condom use at last sexual encounter with a paying partner, among youth and commercial sex workers	Women 15-24 = 24%	Waiting for DHS data
					Men 15-24 = 30%	Waiting for DHS data
					CSW = 80%	Waiting for DHS data

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.1.12 Participate in the continuing fight against malaria	***Objective*** To promote a favorable environment for accomplishing planned activities. ***Summary description:*** Santénet will technically support the finalization of the national malaria policy; assist the MOH/FP in coordinating the Roll Back Malaria (RBM) committee; support implementation of an effective M&E system; and provide technical resources to the MOH/FP and other partners to allow them to more actively participate in national and international fora.	- Production of the national malaria control policy, - Organization of National Malaria Control Day and African Malaria Control Day. - Prepare the strategic planning workshop for the Malaria Control Unit, financial support for the workshop, - Logistical support for the launching of the Residual Indoor Spraying (RIS) Campaign in Amoron'i Mania. - Took part in the team-building retreat for the RBM partnership,.	National policy finalized M&E system established and functioning Participation in national and international events	***PMP indicator # 16*** Policies, standards and protocols (PNP) in Santénet technical areas are updated	3 revised PNP validated by MOH/FP and disseminated: STI/HIV/AIDS, malaria, FP/RH	System is in place to institutionalize and standardize the development and periodic revision and update of the PNP
				PMP indicator # 18 Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met an average of 67% of the standards
Activity 2.1.13 Continue the active participation in the technical IACC for EPI program	***Objective:*** To take part in decision-making and strategy development bodies for EPI. ***Summary description :*** Santénet will continue to provide technical assistance and expertise to the technical and senior IACC for EPI committees to ensure the optimal management of the EPI program	- Work with other partners to improve the national routine immunization program. - Took part in each IACC meeting and Santénet staff Attend in technical subcommittee regular meetings. - Took part in the regular Senior IACC meetings to coordinate activities included in the EPI work plan and to determine strategies to reinforcing the program coordinating body.	EPI Road Map completed IACC meeting notes	***PMP indicator #2*** DPT 3 coverage	65.3%	73%
IR 2.2 – Expanding the Wholesale and Retail Network for Socially Marketed Products						

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.2.1 Expand the private sector and NGO distribution networks to ensure availability of socially marketed products	***Objective:*** To reinforce the capacity of the CBD agents and to ensure availability of socially marketed products ***Summary description:*** Santénet will work in close cooperation with PSI, to train CBD agents in Kôminina Mendrika communes to extend the social marketing distribution network and to facilitate home-based care for certain disease. ***(*) Additional information*** This year 4,400 CBD agents will be trained, i.e. 20 per commune in the 211 New communes of cycle 2	As of the end of September 2006, only 27 new communes had begun Cycle 2 of the KM approach, (8 by Care and 19 by PENSER), therefore to date no new CBDAs have been trained. Furthermore, Cycle 2 of the KM approach in the new communes for the other NGOs will not will not begin until November 2006	Number of points of sale	**PMP indicator #11** Santénet KM have an established distribution system for social marketing products	*64 KM from 2005 have an established distribution chain for Social Marketing products*	81
					211 New communes in which training of CBDAs will take place	N/A-Cycle 2 is just beginning implementation

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 2.2.2 Support NGOs with FP service delivery sites in the management and procurement of contraceptive products.	***Objective:*** Reinforce the availability of FP products for the clients of NGOs through the private sector network. ***Summary description:*** Santénet will work with their partner NGOs, PSI, the MOH/FP and SALAMA to reinforce and expand the NGO procurement network for contraceptive products. ***(*) Additional information*** Santénet will train 11 FP responsible of the NGOs implementing partners of the KM approach	- Support the MOH/FP in providing 3,200 units of IUD to seven NGOs who expressed the need pursuant to the first revitalization workshop held in November 2005. With the goal of training the NGOs FP managers, a reference manual and training curriculum were revised and approved in February 2006.	Number of sites utilizing the full range of FP products	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs
Activity 2.2.3 Support the implementation of a Workplace Initiative targeting the private sector for all areas of Santénet intervention (HIV/AIDS, FP, Malaria, Child Health)	***Objective:*** To facilitate access of workers and their families to health services. ***Summary description:*** Santénet will support to private sector initiatives to improve access to health services and to develop training curriculum for peer educators. Santénet will target companies operating in KM communes and will adapt the KM approach to the workplace: Orinasa Mendrika. ***(*) Additional information*** This year, Santénet will target 7 businesses including 4 in KM communes and	For the results see activity 1.2.3	Standardized peer educator curriculum available Workplace supported	***PMP indicator #12*** Number of social marketing products sold in Santénet KM	Protector Plus® : TBD Sur'Eau® : TBD Pilplan® : TBD Super Moustiquaire: TBD Palustop ® : TBD	Protector Plus® : 114,000 Sur'Eau® : 36,800 Pilplan® : 23,500 Super Moustiquaire: 119,700 Palustop ® : 142,600

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	outside KM					
IR 2.3 –Increase access of priority health services to remote populations						
Activity 2.3.1 Expand private sector/NGO distribution networks to increase access of social marketing products to remote populations, targeting priority biodiversity conservation areas	***Objective:*** To reinforce the capacity of the CBD agents and to ensure availability of socially marketed products. ***Summary description :*** Santénet will work in close cooperation with PSI to train CBD agents in Kôminina Mendrika communes located in priority biodiversity conservation areas to extend the social marketing distribution network and to facilitate home-based care for certain diseases. ***(*) Additional information*** 11 new communes Kôminina Mendrika located in priority biodiversity conservation areas will be	For the results see activity 2.2.1	For the results see activity 1.2.3	**PMP indicator #11** Santénet KM have an established distribution system for social marketing products	*64 KM from 2005 have an established distribution chain for Social Marketing products*	81

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	targeted this year				*219 New communes in which training of CBDAs will take place*	N/A-Cycle 2 is just beginning implementation
Activity 2.3.2 Support the implementation of basic medical coverage strategy	***Objective:*** To improve access to health services. ***Summary description :*** The MOH/FP supports two mechanisms to assist populations to access health services: The Equity Fund will assist the poorest of the poor, while mutuelles –- community based payment schemes – will work with local associations to increase access by those who can make some kind of payment towards health services. As mutuelles become increasingly popular	- Support to the Equity Fund at the CBHC level last year - Support to the MOH/FP, more specifically to its Regional and Referral Hospital Directorate, in developing the hospital-level Equity Fund. - Support in revitalizing the *mutuelles* in Haute-Matsiatra: . analysing situation . drafting and pre-testing guides for establishing the mutuelle , . develop the M&E plan, the actuarial calculation model, the package's cost calculation, and the survey sampling plan, . piloting *mutuelles* in five communes of Fianarantsoa II's DHFPS,	Implementation plan established. Local development councils (LDCs) identified and cost of service delivery estimated, according to the progress chart Mutuelle guide finalized	***PMP indicator #13*** Proportion of curative consultations provided by CBHC in Santénet KM	TBD	In the 5 pilot mutuelle sites, one of which was a KM, visits to the CBHCs increased by 38% during the lean period.

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	and effective mechanism to increase access, the development of a guide for mutuelles will help communities better organize and manage the schemes. Santénet is the MOH/FP's principal partner in this activity, and commits itself to continuing its technical assistance for drafting the guide and monitoring and evaluating the effectiveness of the initiative.	. developing the guide for establishing health insurance schemes in Madagascar, . scaling up the health mutuelle in the regions of Haute-Matsiatra (49) and Vatovavy-Fitovinany (14), . establishing pilot mutuelle in the regions of Ihorombe (3), Atsimo-Atsinana (12), and Amoron'I Mania (9) . training of nine trainers from the Regional Management teams and 67 mangers from the District Management teams on the promotion, implementation, and supervision of *mutuelles* . presenting the partial results of the *mutuelles* of Talata Ampano at the American Public Health Association annual conference. . organizing an open house on *mutuelles* and beginning to scale up in Fianarantsoa in collaboration with the Haute Matsiatra Regional Health Directorate . monitoring the activities to establish health mutuelle in Fianarantsoa: planning (Haute Matsiatra, Vatovavy Fitovinany; Amoron'i Mania, Ihorombe; Atsimo Atsinanana) . developing management tools for the mutuelle				
IR 2.4 – Increasing the Nutritional Value of Agricultural Products						
Activity 2.4.1 To undertake a feasibility study for the introduction "orange	***Objective:*** Explore mechanisms to introduce vitamin-enriched crops to the Malagasy market.	- Contract with AgTech to conduct a feasibility study for the introduction of orange-fleshed sweet potatoes in three regions: Taolagnaro (Fort-Dauphin) in six CCs supported by	KM communes have cultivated and introduced "orange flesh sweet potato" into the local market with Santénet	No specific PMP indicator is directly linked to this activity. However, it will strengthen the overall performance of our		

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
flesh sweet potato" to targeted KM communes	***Summary description :*** Santenet will conduct a feasibility study to examine the viability of the orange flesh sweet potato to local Malagasy markets. Based on recommendations from the study, Santénet and its partners will encourage initiatives with community vegetable garden programs in 10 pilot communes in KM to introduce the orange flesh sweet potato as a vitamin-A rich crop and a source of revenue for local farmers. ***(*) Additional information*** The introduction of the orange flesh sweet potato will be piloted in 10 communes in KM	ASOS Sud, in Ambatondrazaka in two communes supported by Mateza, and in Vatomandry in four communes supported by CARE. Because of the growing season of the orange sweet potatoes, planting season is between January and March, therefore this activity will begin in the 10 pilot communities in early 2007.	funds	programs with integration to economic growth sector		
IR 2.5 – Improving Water Management for Agriculture and Households						
Activity 2.5.1 Improve the environmental hygiene and sanitation component (including promotion of the Sur'Eau) through an integrated plan of action	***Objective:*** Improve water quality in the intervention areas. ***Summary description :*** Santénet and the partners identified will establish integrated plans of action together and distribute the tasks by prioritizing environmentally vulnerable areas. Santénet will provide financial support for initiatives to improve the environmental hygiene and sanitation components in two pilot areas per	- In January 2006 contribution to the formation of the WASH committee in Fianarantsoa - In February 2006Agreement of Santénet to incorporate water and sanitation messages in KM tools and activities - In October 2006Recruitment of a water and sanitation consultant to begin working with the KM to expand the use of integrated sanitation and hygiene, contribute to the advancement of the WASH initiative and provide technical assistance in areas of latrine building,	Plan of action established and coverage assessment report	***PMP indicator #12*** Number of social marketing products sold in Santénet KM	Sur'Eau® : TBD	Sur'Eau® : 36,800

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	province.	spring capping, implementation of gravity flow water systems, and simple irrigation dam design in collaboration with ERI, in Fianarantsoa and Toamasina				

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR 3: Improving the Quality of Selected Health Services						
IR 3.1 – Improving Policies, Standards and Protocols (PSP) for Public and Private Sector Health Services						
Activity 3.1.1 Support the ratification of the national RH policy and the updating of the RH standards and protocols	***Objective:*** Support the MOH/FP in updating the RH national policy, standards and protocols. ***Summary description:*** Santénet will support the revision process by updating the working group members with regard to new	- Santénet funded a workshop in May 2006 which made significant changes to the standards document. - Review the resulting draft by the Safe Motherhood Unit between May and July 2006	The national policy in reproductive health is updated and ratified. The RH standards and protocols are updated again	***PMP indicator #16*** Policies, standards and protocols (PNP) in Santénet technical areas are	1 technical area having its PNP revised: FP/RH 3 revised PNP validated by MOH/FP and disseminated:	To be revised because the system to institutionalize and standardize the development and periodic revision and update of the PNP (initially

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	**Benchmark 2006**	**Progress towards benchmark**
	scientific data in RH, organizing consensus-building meetings, holding a national ratification workshop, and dissemination of documents to health facilities.	- The MOH/FP plans to endorse the report in November 2006 following the RH technical coordination meeting.		updated	STI/HIV/AIDS, malaria, FP/RH	targeted in our PMP) was already set up in 2005
Activity 3.1.2 Develop desired performance standards for child health	***Objective:*** Incorporate child health into the Performance and Quality Improvement (PQI) approach in the health facilities. ***Summary description:*** Activities will be undertaken to develop standards of desired performance in child health based on existing national reference documents and international reference documents from WHO and UNICEF. These standards, the IMCI clinical guide and the new national child health policy will serve as reference documents for revising and simplifying teaching tools for the PTIs, namely the IMCI training curriculum, the learning guides, the IMCI algorithm, and the student workbook.	- A workshop to draft standards for Child Health. based on national and international reference documents, was organized in February 2006 for MOH/FP senior technical staff, Befelatanana Hospital maternity staff representatives, and members of Santénet's IR3 team, - In September 2006 the final version was submitted to the Directorate of Child Health for review and approval. - This document has since been used to update the Integrated Management of Childhood and Newborn Infection (IMCNI) decision making tools by the ministry of health in May 2006.	Desired performance standards available	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met an average of 67% of the standards

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR3.2 – Improving Service Providers' Ability to Deliver Quality Health Services						
Activity 3.2.1 Organize a training workshop on designing teaching programs for advanced trainers	***Objective:*** Create of a core group of qualified and competent trainers at the national and regional levels. ***Summary description :*** 23 advanced trainers were trained in 2005 will be trained in techniques curricula and program development and will be used to update the RH, EONC and child health training curricula.	- Twenty-three advanced trainers participated in a training workshop in curriculum development techniques in November 2005 with JHPIEGO/Baltimore's technical support and Santénet's financial support - During this workshop participants updated the national integrated FP training module and developed an FP reference guide, a trainer guide and a participant guide. The revised module was tested and used during in-service training of service providers in practicum sites and in KM CBHCs. .	Advanced trainers updated in FP, trained in designing teaching programs	***PMP indicator #17*** MOH/FP training curricula updated in each of the Santénet technical areas	3 training curricula (STI/HIV/AIDS, Malaria, FP/RH) revised in agreement with updated PNP Adequacy assessed for the components related to 2 remaining technical areas in the curricula (IMCI and Nutrition)2 revised curricula (IMCI and Nutrition) used in the six IFP	Malaria and FP have been completed. STIs will be completed during the 2006-2007 reporting period. Standards have been developed for IMCI and Nutrition, from which curricula can be assessed.
Activity 3.2.2 Update advanced trainers in STI and CPC/PMP	**Objective:** *Create a core group of qualified, competent trainers at the national and regional level.* ***Summary description :*** In order to become qualified advanced trainers, the 23 advanced trainers trained in 2005 each facilitated one module during the training of trainers (TOT). In 2006, the master trainers will facilitate the TOT for the KM CBHC providers. These master trainers will receive updated training in STI and CPC/PMP. The training session will be led by a Santénet trainer and a resource person from MOH/FP.	- In June and July of 2006, eight advanced trainers facilitated district level trainings in STI and CPC/PMP (described in more detail in Activity 3.2.3).	Advanced trainers updated in STI and CPC/PMP	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 3.2.3 Update training-of-trainers candidates in IP, FP, STI, and CPC/PMP	***Objective:*** Create a core group of qualified and competent trainers at the national and regional level. ***Summary description :*** 25 candidates for training of trainers will be identified based on clearly defined selection criteria to participate in a ten-day TOT to train the KM CBHCs.	In June 2006, Santénet and the MOH/FP organized a one-week session in FP, STI, IP, FPC/IPT techniques for 24 candidate trainers from 22 districts and two regional Santénet offices to expand the pool of trainers that can train service providers in the DM.	Trainer candidates updated and competent in the technical areas indicated	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
Activity 3.2.4 Organize training-of-trainers workshops	***Objective:*** Create a core group of qualified and competent trainers at the national and regional level. ***Summary description:*** The 25 TOT candidates will be trained and in order to become qualified, they are to offer training sessions to the service providers working in the KM CBHCs and the practicum sites.	Twenty-four of the candidate trainers attending the STI, IP, FPC/IPT techniques training (described in activity 3.2.3.) were also invited to attend a five-day TOT training, and all were subsequently qualified as trainers of trainers. - A one week training of trainers in clinical techniques for partner NGOs' trainers organized in July 2005. Twenty-two (22) trainers were selected, and trained in the most recent IP techniques and clinical training skills.	Participants promoted to the status of master trainer	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
				PMP indicator #19 Percentage of CBHC meeting "Quality CBHC" criteria in the KM	60%	Assessment to be done in January
Activity 3.2.5 Train the trainer supervisors in techniques of supportive supervision	***Objective:*** Create a core group of qualified and competent trainers at the national and regional level. ***Summary description*** : The training will develop skills at the CBHC level, which will allow the CBHC to auto-evaluate, follow up on its own activities, and improve problem areas between external supervisory visits. A core group of 25 supervisors, 20 from the regional level and the KM MOH/DHFPS and five	In November 2005, Twenty-five (25) participants for district level external supervisors and practicum site internal supervisors (including three Santénet staff members) were trained in facilitative supervision skills. - Five of the trained supervisors were later involved in the series of monitoring and evaluation visits in practicum sites that had introduced QAS.	Supervisors trained as trainers in the supportive supervision technique	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
				PMP indicator #19 Percentage of CBHC meeting "Quality CBHC" criteria in the KM	60%	Assessment to be done in January

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	from the central level (including a representative of the following MOH/FP services: FP, STI, PMP, and child health) will be selected to participate in the TOT. These participants will, in turn, train the internal supervisors at the practicum sites and at the KM CBHCs, as well as the SSD and the KM partners.					
Activity 3.2.6 Train the external supervisors of the MOH/DHFPS and KM partners and the internal supervisors at the practicum sites and KM CBHCs in supportive supervision.	**Objective**: *Improve the quality of supervision in the health facilities and offer the service providers and external supervisors the opportunity to interact and work as a team to remedy existing weaknesses.* ***Summary description:*** Workshops will be held to train supervisors from the 27 MOH/DHFPS and the KM commune partners, as well as internal supervisors from the practicum sites. ***(*) Additional information*** After revision, two (instead of three) workshops will be held to train 50 (instead of 67) supervisors from the 27 MOH/DHFPS. 61 (instead of 75) competent supervisors will be trained to supervise the service providers and, as initially planned, 11 internal supervisors from the practicum sites will be trained.	- Training of District level external supervisors and KM CBHC internal supervisors in facilitative supervision skills: two five-day training sessions in September and October 2006 included 44 participants (instead of 50). - As follow up to this training, some participants will be involved in the training supervisors in the new Champion Districts during 2007, monitor the application of the QAS in the KM CBHCs and supervise trained providers. Santénet will also support implementation of the action plans developed during the training.	Competent supervisors trained to supervise the service providers	***PMP indicator #19*** Percentage of CBHC meeting "Quality CBHC" criteria in the KM	60%	Assessment to be done in January
Activity 3.2.7 Update the service	***Objective:*** improve the quality of services in the KM	- Train 130 in-service providers from 50 CBHCs in FP, using the newly revised integrated FP, IP, and STI modules. - Eight sessions were organized from	Training report	***PMP indicator #19*** Percentage of	60%	Assessment to be done in January

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
providers from the KM communes' CBHCs	communes' CBHCs. ***Summary description :*** For category 1 CBHCs (40) with an average number of three service providers: refresher courses in IP, FP, STI, CPC, and PMP will be offered in three ten-day workshops with 25 people per workshop. For category 2 (49) and three (38) CBHCs, the update workshops will be offered at the same time as the monthly technical meetings for each SSD. The SSD trainers will be asked to include a day for a refresher module on FP, STI, and CPC/PMP at the time of the technical meetings. The total length of time for covering the topics is not to exceed 10 days. All service providers, regardless of classification, will be updated in IP on site, for two days per site. ***(*) Additional information*** Santénet will focus its efforts on 40 Category 1 CBHCs out of 147 CBHCs. A total # of 186 service providers will be trained	August to September 2006 to provide participants with skills in these three technical areas. - As a result, 23 of 46 candidate trainers were certified. The remaining 23 candidate trainers are expected to be certified in 2007 during TOTs scheduled in the nine DM.		CBHC meeting "Quality CBHC" criteria in the KM		
Activity 3.2.8 Monitor trainees (trainers and service providers)	***Objective:*** improve the quality of services in the KM CBHCs. **Summary description:** *Santénet will develop a monitoring plan which takes into account human resource and logistical constraints. For instance, monitoring could be incorporated in the routine supervisory visits and monitoring of PQI activities by the SSD or the KM*	- Qualification of 11 master trainers - Eight advanced trainer candidates, 23 trainer candidates, and two regional supervisors who had attended trainings went on to be qualified this year.	Assessment report	***PMP indicator #19*** Percentage of CBHC meeting "Quality CBHC" criteria in the KM	60%	Assessment to be done in January

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	partners, or the project could employ a questionnaire (developed and distributed by Santénet) that would be filled out by the health agents and compiled by the regional supervisors for analysis.					
Activity 3.2.9 Provide appropriate teaching materials for the practicum sites to support supervision of the students	***Objective***: Facilitate supervision of the students. ***Summary description :*** In 2005, Santénet provided the training institutions with many educational tools, which were distributed, and with anatomical models of the female pelvis (Zoë model) to help train service providers. In 2006, new needs for such material were expressed by the practicum sites and the training institutions. ***(*) Additional information*** Requests came from 4 practicum sites (maternity wards in the health-care facilities in Toamasina, Toliara, Fianarantsoa and the university hospital in Befelatanana) and 4 training institutions Santénet intervention provinces.	-Distribution of 200 copies of a document and CD-ROMs on standards-based management , which were distributed during the advocacy and orientation meetings in the DM. - Two hundred (200) copies of a reference document on effective teaching witch have translated from English into French were printed and distributed to participants from the paramedical schools and medical school attending a training workshop referred to in activity 3. 2.12)	Documents and educational materials made available to the practicum sites and the training institutions	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
Activity 3.2.10 Organize refresher courses for service providers at the practicum sites	***Objective:*** Meet the training needs identified in the 2005 PQI action plans. ***Summary description :*** After developing the desired performance standards in FP, STI and CPC/PMP and implementing them at the sites, a need to bring a certain number of training modules up to date again was identified. This includes an	In order to meet additional needs identified in the QAS action plans 35 service providers were trained in FP QAS and 27 in STI QAS between December 2005 and February 2006 for seven sites in Antananarivo and five regional practicum sites.	Training report	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones *(as students provide health care services at the end of their study)*	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	update to service provider knowledge and skills to comply with the defined standards. Training topics include contraceptive technology and FP counseling, syndromic management of STIs, and STI/HIV counseling. ***(*) Additional information*** 25 service providers will be updated in contraceptive technology and FP counseling 25 service providers will be trained in syndromic management of STI					
Activity 3.2.11 Support the revision and duplication of IMCI and ENA teaching tools	***Objective:*** Ensure adequate supplies are regularly provided to teaching institutions in a sustainable way. ***Summary description:*** PTI and the Faculty of Medicine requested that Santénet facilitate the revision and simplification of the IMCI and ENA training modules developed by Linkages and MOH/FP. Santénet will work with the MOH and Linkages, providing technical and financial assistance to this activity.	- In November 2005 two workshops, to draft the protocols for supervising IMCI and Essential Nutrition Actions (ENA) were organized. - In Mai 2006 the IMCIN decision making tools was revised during a five-day workshop. Its finalization and approbation planned in 2007. - In August 2006 the national protocol for supervising IMCIN was revised, printed, and distributed - The revision of the IMCNI in-service training curriculum that was initiated in 2006 will continue into 2007	Lasting system for providing teaching materials to students in place Revised and approved teaching documents available to training institutions in sufficient quantity	***PMP indicator #17*** MOH/FP training curricula updated in each of the Santénet technical areas	3 training curricula (STI/HIV/AIDS, Malaria, FP/RH) revised in agreement with updated PNP Adequacy assessed for the components related to 2 remaining technical areas in the curricula (IMCI and Nutrition)2 revised curricula (IMCI and Nutrition) used in the six IFP	Malaria and FP have been completed. STIs will be completed during the 2006-2007 reporting period. Standards have been developed for IMCI and Nutrition, from which curricula can be assessed.
Activity 3.2.12 Train the IMCI supervisors, evaluators and teachers at the PTI and Faculty of Medicine in Effective Teaching	***Objective:*** Create a core group of qualified, competent trainers in the medical training institutions. ***Summary description:*** The objective of the training is to make teaching more	In November 2005 two training sessions to build effective teaching skills among faculty and instructor were organized: 46 medical school faculty members and 48 paramedical school instructors were trained	Training report	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Skills	participatory and active and to ensure effective monitoring of the IMCI and ENA training modules ***(*) Additional information*** 20 teachers from the faculty and 20 monitors from PTI trained as trainers and capable of leading training sessions in class using adult education methods.			*(as students provide health care services at the end of their study)*		
Activity 3.2.13 Train the monitors and supervisors in essential nutrition actions (ENA)	***Objective:*** strengthen the trainers' technical skills and improve student monitoring for nutrition internships. ***Summary description:*** A five-day ENA workshop will be held for 25 PTI supervisors and monitors. The revised training curriculum mentioned in Activity 3.2.11 will be used for this purpose. Each of these trained agents will be monitored during practice training sessions, and upon successful completion, each will be qualified as a competent trainer. ***(*) Additional information*** 25 monitors and training supervisors trained in the adult education methods and qualified as trainers	As part of its collaboration with Santénet, the Linkages Project, has committed to updating the paramedical schools on ENA, Activity 3.2.13. This partnership is ideal given their expertise and had previously revised ENA module.	Monitors and training supervisors qualified as trainers	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones *(as students provide health care services at the end of their study)*	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
Activity 3.2.14 Revise the emergency obstetric and neonatal care (EONC) training	***(*) Additional information*** After revision of its priority programs, Santénet decided to not conduct this activity for this	This activity was not implemented because of the technical and geographical breadth of the activity, the resulting technical and financial constraints, and the UNFPA previous activities in the area.				

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
curriculum for hospitals	2nd year. Some components were integrated in other parts of the workplan, some were taken by other MOH/FP partners and some will be carried out later next year.					
Activity 3.2.15 Provide monitoring for trainees (trainers and service providers)	***Objective:*** Support the supervisors and trainers in improving the quality of teaching. ***Summary description:*** Monitoring visits to the PTI and Faculty of Medicine will be scheduled to evaluate implementation of skills gained during training. Joint visits by Santénet and the training institutions will be scheduled twice a year. ***(*) Additional information*** The 4 PTI and the Faculty of Medicine Antananarivo will be monitored	We were not able to supervise the implementation of faculty and instructor action plans described in this because participants did not receive adequate support from their supervisors after the training.	Field visit monitoring report	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones *(as students provide health care services at the end of their study)*	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
IR3.3 – Implementing Operational Models for Quality Assurance of Selected Health Services						
Activity 3.3.1 Ensure monitoring of action plan implementation at the practicum sites	***Objective -*** Support the 11 practicum sites in improving quality of service delivery ***:*** ***Summary description:*** Santénet and the MOH/FP will undertake joint monitoring visits with to evaluate progress made in implementing the individual action plans and in achieving defined performance standards. Based on the recommendations made during the visit, the sites' action plans will be revised and implemented. The team will use	The ten practicum sites were visited twice between December 2005 and January 2006. As part of the first visit, the sites received recommendations from supervisors. Upon the second visit, it was noted that 80-95% of the action plans had been implemented.	-Evaluation report from each site visit- All action plan implemented	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	**Benchmark 2006**	**Progress towards benchmark**
	the documents containing the standards and the action plan as monitoring tools.					
Activities 3.3.2 Provide chlorine-manufacturing equipment to four regional hospitals	**Objective** - *Provide a regular and adequate supply of concentrated chlorine solution to 4 regional hospitals which are practicum sites:* ***Summary description :*** Santénet will support (maternity wards in the health-care facilities in Toamasina, Toliara, Fianarantsoa and the university hospital in Befelatanana which are practicum sites) by purchasing machines to make chlorine, which will then be able to supply the neighboring CBHCs. A feasibility study is being developed and a cost-benefit analysis of this assistance is in process, which looks at existing storage facilities and availability of raw materials, and human resource/training needs for the machine operator.	- The feasibility study confirmed that the human and raw material resources were available at all the sites. Electric machines supplying a daily output of 200 liters of chlorine were selected - One machine was delivered and installed in July 2006 in Toliara. Ten other machines will be installed in December 2006.	Chlorine-making machine is available and operational.	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
Activity 3.3.3 Conduct PQI monitoring visits	***Objective:*** improve the quality of service at the practicum sites. ***Summary description :*** The team who helped introduce PQI at the practicum sites will evaluate the progress and make recommendations.	In March 2006 ten (10) practicum sites were visited to assess performance improvements in IP, FP, and STI.	Rapport d'évaluation des sites de stage	***PMP indicator #18*** Performance standards achieved by practicum sites in Santénet intervention zones	All selected sites meet at least 40% of established performance standards.	All met 67% of the standards
Activity 3.3.4 Introduce PQI in the Mendrika communes'	***Objective:*** Improve the services offered in the KM CBHCs. ***Summary description :*** The introduction process will be	40 Category 1 and 10 category 2 CBHCs were selected to implement PQI. - In October and November 2005 thirty-nine CBHCs were visited to assess needs.	PQI action plans developed and implemented LCC and evaluation teams	***PMP indicator #19*** Percentage of CBHC meeting "Quality CBHC"	60%	Assessment to be done in January

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
CBHCs	preceded by contact visits to the KM communes' category 1 CBHCs (these are the CBHCs with a good infrastructure and adequate staff) where PQI will be systematically introduced. At the end of the process, CBHCs that meet the defined level of performance will be certified as "quality CBHCs". ***(*) Additional information*** There are 40 category 1 CBHCs	- Four workshops were organized in December 2005 and January 2006 in Toliara, Toamasina, and Antananarivo: one hundred people were trained on the QAS methodology based on the QAS/PQI approach. . Forty-six of 50 CBHCs were assessed from January to April 2006. Four centers could not be assessed as one did not have staff, two in Toliara were inaccessible during the evaluation period due to rain, and one had merged with another CBHC.	established and functional	criteria in the KM		
Activity 3.3.5 Scale up SDM in the public and private sectors	***Objective:*** Support MOH/FP in scaling up SDM. ***Summary description :*** A pilot study to introduce the Standard Days Method of natural family planning will be evaluated. The anticipated results will help MOH/FP decide whether to expand the method to new public and private sites. Santénet will ensure that service providers in these centers are trained in cooperation with those trained in 2005. ***(*) Additional information*** Service providers in 10 centers will be trained this year ; 200 community-based outreach workers and distribution agents working near the expansion CBHCs will be trained to promote the method, i.e. 20 per site	- In July 2005: introduction of the Standard Days Method in 27 health centers - 29 service providers were trained - 270 community-based outreach workers and distribution agents working near the expansion CBHCs were trained to promote the method, - In April and May 2006 (after ten months of implementation), an assessment was conduct by the National Public and Community Health Institute Results: 624 women adopted the method - In late June 2006A a workshop to share results was organized. - In September 2006, scale up plan developed with a consultant from the Georgetown University Institute for Reproductive Health (IRH).	Additional sites offering the SDM method	No specific PMP indicator is directly linked to this activity. However, it will facilitate the achievement of our PMP indicator # 1(Contraceptive prevalence rate)		

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR 4: Improving the Institutional Capacity to Implement and Evaluate Health Programs						
IR 4.1 – Improving Collection and Use of Data for Decision Making						
Activity 4.1.1 Aid in the Update of HMIS Management Tools	**Objective**: To improve the quality of the data in the HMIS. ***Description**: Santénet will help the MOH/FP to provide HMIS management training, to ensure adequate equipment for the regions and to monitor the data managers in targeted regions. By helping the MOH/FP implement the recommendations of the HMIS assessment, Santénet will participate in updating the HMIS management tools.* **(*) Additional information** *This year, 28 districts in the 4 provinces of SN intervention will be included in this activity and data managers of 16 regions will be trained*	The PARP project funded by the European Union financed GESIS installation and systems training, and Santénet provided technical and financial support to train MIS managers in 16 of 22 regional directorates as well as four remote District Health Services in GESIS.	Management tools updated Training reports Monitoring reports	***PMPindicator #20*** CBHCs in Santénet Champion Communes produce quality monthly activity reports	17%	32%
Activity 4.1.2 Participate in Establishing the National HMIS Policy	***Objective:*** To contribute to the establishment of a national HMIS policy. ***Description:*** Santénet will participate in establishing this national policy. ***(*) Additional information*** 6 workshops will be organized for the development of the policy, with a 1 day dissemination workshop. Santénet will edit and document 1000 copies of the document	Actions plans to implement the strategy will be discussed at meetings scheduled for November 2006. This result as described in the 2005 workplan was not reached during this reporting period, activities for Health Statistics Unit were focussed on creation of the MAR and the different trainings in the new MAR and GESIS software (see activity 4.1.1) This activity is postponed in 2007	National SIS policy established	***PMPindicator #20*** CBHCs in Santénet KM produce quality monthly activity reports	17%	32%

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	**Benchmark 2006**	**Progress towards benchmark**
Activity 4.1.3 Reinforce the Capacities of the Communes and CBHCs to Effectively Use Health Data	***Objective***: To improve data for decision making on the local level. ***Description:*** Santénet, in partnership with the MOH/FP, will pilot implementation the chartbook by training the managers and leaders of each commune and through regular monitoring. ***(*) Additional information*** After revision of its priority with the MOH/FP staff, Santénet decided to support the training of 147 CBHC managers and 28 SSD managers in all 81 KM cycle 1 on use of the chartbook, instead of introducing the tool in only five to 10 Communes.	DHFPS clinic and CBHC staff in KMs were trained in DDM, particularly using data collected in the MIS between November 2005 and May 2006: the heads of 155 CBHCs located in all 81 of Santenet's KMs, 29 district level MIS managers, and 10 MIS managers from the Regional Directorates were participating in those training.. - Assessment of the MIS performance for reliability, validity, completeness, timeliness, in collaboration with Prospect International and the MOH/FP Health Statistics Unit, using a participatory methodology Evaluation results showed that the percentage of CBHCs regularly sending MARs and meeting the criteria of accuracy, timeliness, and completeness increased from 14% in 2004 to 32% in 2006 following the trainings.	Training report Monitoring report	***PMPindicator #21*** Use of routine data at the CCBHC level in Santénet KM	48 communes from 2005 using Chartbooks 211 New communes in which the chart book will be implemented [To be revised because activities will be conducted in two phases of 18 months instead of 3 phases of 12 months]	81 KMs were trained in the use of a revised version of the chartbook and DDM.
IR4.2 – Expanding Access to Health Information						
Activity 4.2.1 Support sharing of health information	***Objective:*** To improve the sharing of lessons learned and information through the stakeholders. ***Description***: Santénet will seize all opportunities to help the MOH/FP and partners use information better. ***(*) Additional information*** This year, Santénet will organize 12 workshops to share health data and information with MOH/FP partners in its 4 provinces of intervention.	This activity aimed to work directly with MOH/FP to increase opportunities for information sharing and exchange, however, due to the lack of availability of program and ministry staff to act as counterparts, this activity was not accomplished. It is planned for the upcoming year.	Report on dissemination and sharing activities	***PMPindicator #21*** Use of routine data at the CBHC level in Santénet KM	48 communes from 2005 using Chartbooks 219 New communes in which the chart book will be implemented	81 KMs were trained in the use of a revised version of the chartbook and DDM.

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
IR4.3 – Improving NGO Capacity to Implement Health Programs						
Activity 4.3.1. Help the MOH/FP Implement Activities Related to the National Contracting Policy for Health	***Objective:*** To institutionalize the mechanism for contracting for health services. ***Description:*** Santénet will support the process to establish the practical guide on NCPH. Then, Santénet will participate in facilitating the implementation of these guides by the contracting parties. ***(*) Additional information*** 3 series of workshops are scheduled this year	- Training 25 trainers from six Regional Directorates and several NGOs in contracting, using the National Contracting Policy - Training five regions in the Fianarantsoa province in contracting. Outside the regions, the trainings reached 25 DHFPS Fianarantsoa province and select health NGOs in the regional capitals.	Activity report Guide established	***PMP indicator # 6*** Number of communes that achieve Santénet Champion Commune status	64 communes from 2005 reaching 1st level of KM status and involved in next step 211New communes in which KM approach will be introduced	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.
Activity 4.3.2 Support the FP Partnership	***Objective:*** To support the implementation of the new FP strategy. ***Description:*** Santénet will help the MOH/FP organize meetings intended to establish and make operational this FP partnership. ***(*) Additional information*** 1 meeting will be organized	For results, see activity 2.1.2.	FP partnership operational	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 4.3.3 Facilitate partners' capacity to implement the Kôminina Mendrika approach	***Objective***: Ensure that NGOs are able to implement the health program and focus Santénet actions on KM objectives. ***Description***: Santénet will conduct discussion workshops with its partners every 6 months. IR4 will reinforce the partners' capacity for increased effectiveness (more competitive partners that need less supervision) and increased efficiency (reduce implementation costs).	In April, Santénet hosted a mid-term workshop for partners to reflect upon achievements and accomplishments in the use of the KM approach. For results, see activity 1.1.1	Biannual review workshops conducted	***PMP indicator # 6*** Number of communes that achieve Santénet Champion Commune status	64 communes from 2005 reaching 1st level of KM status and involved in next step 211 New communes in which KM approach will be introduced	25 of 81 KM have been certified during this reporting period. During 2006, the KM cycle was extended to 15 months, and will now end Oct. 31, 2006, so it is expected that the number of those reaching KM status will reach the indicator level by the end of the contracting period. The KM approach has been introduced in 28 new communes for Cycle 2 as of the end of this reporting period.
				PMP indicator #8 Number of communes in priority biodiversity conservation areas that achieve Champion Commune status	10	2 Due to the extension, 9 are expected to be certified in October

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
Activity 4.3.4 Help the ES/NACC organize thematic working groups	***Objective:*** To contribute to establishing a common vision and encourage communication. ***Description:*** Santénet will participate in the design and provide financial assistance to create a national forum to address specific topics of concern in the fight against HIV/AIDS	- Participation at the festivities marking World AIDS Day 2005 in Toamasina, 200 young people were targeted with messages on HIV prevention, screening, and psycho-social care of PLHAs. - In collaboration with the MOH/FP, the Regional Directorates of Ihorombe and Atsimo-Andrefana, the DHFPS of Ihosy and Sakraha, Médecins du Monde, SALFA and the BAMEX project, Santénet organized and funded education and information activities targeting specifically sapphire miners in Ilakaka and Sakaraha. 68 miners from Ilakaka and 93 in Sakaraha attended those activities	National forum conducted	***PMP indicator #4*** Condom use at last sexual encounter with a paying partner, among youth and commercial sex workers	Women 15-24 = 24%	Waiting for DHS data
					Men 15-24 = 30%	Waiting for DHS data
					CSW = 80%	Waiting for DHS data
Activity 4.3.5 Monitor the application of the STI guide	***Objective:*** To measure the effectiveness of the IHAA STI Guide in increasing awareness of risks associated with STIs. ***Description:*** A quantitative and qualitative assessment will be carried out to measure the effectiveness of the IHAA STI Guide in increasing awareness and changing behavior to reduce the risk of STI (including HIV/AIDS) transmission.	In June 2006, Santénet hosted two participatory workshops to assess whether or not peer educators found the IHAA STI Guide useful. 25 participants attended those workshops.	Assessment report	***PMP indicator #4*** Condom use at last sexual encounter with a paying partner, among youth and commercial sex workers	Women 15-24 = 24%	Waiting for DHS data
					Men 15-24 = 30%	Waiting for DHS data
					CSW = 80%	Waiting for DHS data
IR4.4 – Increasing Civil Society's Capacity to Advocate for Public Health Issues						
Activity 4.4.1 Assist the religious leaders' platform to support the new FP and HIV/AIDS strategy.	***Objective:*** To encourage religious leaders to participate in and support the objectives of the new FP and HIV/AIDS strategy. ***Description:*** Following the proposal submission by the	- Santénet assisted the platform in developing and submitting a concept paper to World Learning that requested funding for a three-year project to promote FP throughout the country. - In May 2006, USAID/Washington awarded them this grant through the Flexible Fund account	Platform activity reports available	***PMP indicator #1*** Contraceptive prevalence rate (increments of 1.3% per year)	20.6%	Waiting for DHS data. Rate of coverage in public sites is 6.5% according to MARs

Activities	Objective Summary description (*) Additional information	Progress against objective	Means of Verification	Performance Indicator (PMP)		
				Indicator	Benchmark 2006	Progress towards benchmark
	religious leaders' platform to the Flex- Fund and other donors, Santénet will continue its support to the platform to implement its activities, specifically their information-sharing meetings, and to assist in monitor activities. In addition, the team will support the preparation of the next submission to maintain continuity for the platform's program.	- After the concept paper was approved, Santénet assisted the platform in organizing workshops for each individual group to plan and develop action plans, including budgets. - In June 2006, the platform began its planned activities, developing a project implementation plan, training members in project management, training trainers, and collecting baseline data.				

CHAPTER NINE

ADMINISTRATION AND OPERATIONS

ACHIEVEMENTS AND CHALLENGES FOR THE REPORTING PERIOD

Staffing Changes. Santénet lost its Director of Finance and Administration in June 2006, necessitating a rapid search for a replacement. Santénet's home office project manager was identified as the best candidate to ensure a smooth continuation of financial and administrative controls and minimal disruption project activities. She relocated to Madagascar to serve as the new DAF, beginning her duties mid-August 2006.

Santénet underwent further organizational restructuring in our regional office in Fort Dauphin. In this reporting period, the position of regional Program Assistant's was eliminated. Further changes scheduled for the beginning of the next reporting period will relocate of our health program manager to Tana to serve as SDM program coordinator, and the hiring of a community mobilization specialist and a health service quality specialist for Fort Dauphin. The Santénet office will also relocate to the DRS offices to work more closely with the Anosy Regional Health and Family Planning Directorates and the Health District of Amboasary.

Internal control procedures monitored and improved. A field accountant from Chemonics' headquarters visited the project in May to conduct a mid-project internal review/audit of the financial records, bookkeeping and accounting systems. The results of this review/audit were shared with USAID and suggestions for improvement were incorporated into Santénet's daily administration and financial procedures.

Productive, cost-effective administrative relationship with other projects. Santénet continues to diligently explore cost-sharing opportunities, sharing regional offices with our partners, MCDI, CARE, MISONGA and ERI and providing office space to other partners like HCP and BASICS. Next semester will see the incorporation of two additional BASICS and BASICS Immunization staff members, five staff members of HIP, and three members of the LINKAGES team in our Tana office space.

State-of-the-art information and communication technology. In addition to our actual internet access connections, our several phone lines and the fleet subscription with a cellular phone company, we have set up SKYPE connections to facilitate real-time communication and realize considerable savings for international communication.

Santénet has also been one of the pilot projects at Chemonics to role out our new accounting software: ABACUS (Automated Business Accounting Connection System) to replace QuickBooks. ABACUS is a multi-user Web-enabled accounting software which allows the Chemonics home office better oversight and control over the way field offices book expenses by allowing for the real-time transfer of information between the home office and field office.

As a result, ABACUS will help reduce errors and allow the home office PMU and field accounting groups more time to review project expenses prior to invoicing.

Compliant and standardized financial, management and administrative systems. To maximize our efficiency and accountability, we actively seek means to improve procedures and ensure compliance with USAID financial requirements. The first table below shows our expenditures by CLIN against our annual budget. The second table shows our expenditures by CLIN and Source of Funding against our budget and obligation.

EXPENDITURES THROUGH SEPTEMBER 30TH, 2006

	Lignes budgétaires	TOTAL	CLIN 1			CLIN 2			CLIN 3			CLIN 4			CLIN 5 Inactive	Total Remaining
		BUDGET	BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	EXPENDITURE	Budget
1	SALARIES	2,346,993	645,879.00	316,877.86	**329,001.14**	703,708.00	418,178.48	**285,529.52**	532,917.91	254,066.53	**278,851.38**	432,894.00	381,926.99	**50,967.01**	31,594.09	944,349.05
2	FRINGE	782,375	216,954.00	92,304.95	**124,649.05**	233,180.00	110,818.78	**122,361.22**	182,123.00	74,233.22	**107,889.78**	137,820.00	89,959.38	**47,860.62**	12,297.50	**402,761**
3	OVERHEAD	1,732,200	478,434.00	208,409.10	**270,024.90**	522,096.00	281,924.34	**240,171.66**	394,251.00	163,528.49	**230,722.51**	313,739.00	247,226.85	**66,512.15**	23,679.61	**807,431**
4	TRAVEL & TRANSPORTATION	326,098	82,902.00	63,173.76	**19,728.24**	91,486.00	91,512.82	**-26.82**	80,172.00	56,471.21	**23,700.79**	53,938.00	53,469.45	**468.55**	17,600.40	**43,871**
5	ALLOWANCES	701,658	189,828.64	110,536.06	**79,292.58**	206,359.00	130,460.24	**75,898.76**	170,478.00	85,230.85	**85,247.15**	122,554.00	84,935.04	**37,618.96**	12,438.36	**278,057**
6	OTHER DIRECT COSTS	1,687,442	448,415.00	131,078.19	**317,336.81**	496,494.00	134,451.31	**362,042.69**	432,408.00	143,658.30	**288,749.70**	292,362.00	128,546.94	**163,815.06**	17,763.12	**1,131,944**
7	EQUIPEMENT, VEHICLES & FREIGHT	299,470	64,277.00	75,786.50	**-11,509.50**	69,789.14	77,824.54	**-8,035.40**	60,584.00	73,999.51	**-13,415.51**	41,237.00	67,647.43	**-26,410.43**	63,582.86	**-59,371**
8	TRAINING	1,736,789	464,532.00	278,612.90	**185,919.10**	514,848.00	338,792.74	**176,055.26**	452,284.00	176,683.02	**275,600.98**	303,380.00	81,420.56	**221,959.44**	1,744.59	**859,535**
9	SANTENET FUND	1,999,999	535,435.00	251,844.12	**283,590.88**	593,476.00	178,411.75	**415,064.25**	521,380.00	178,411.75	**342,968.25**	349,708.00	107,100.92	**242,607.08**	0.00	**1,284,230**
10	SUBCONTRACTS	3,410,521	436,640.00	130,158.08	**306,481.92**	1,029,921.00	348,717.29	**681,203.71**	1,218,080.00	724,532.63	**493,547.37**	695,218.00	450,165.33	**245,052.67**	30,661.70	**1,726,286**
	SUBTOTAL	**15,023,544**	3,563,296.64	1,658,781.52	**1,904,515.12**	4,461,357.14	2,111,092.29	**2,350,264.85**	4,044,677.91	1,930,815.51	**2,113,862.40**	2,742,850.00	1,692,398.89	**1,050,451.11**	211,362.23	**7,419,093**
11	G&A	600,942	142,240.00	82,758.21	**59,481.79**	178,090.00	105,333.18	**72,756.82**	161,358.00	96,485.78	**64,872.22**	109,668.00	84,580.74	**25,087.26**	9,586.06	**222,198**
12	FIXED FEE	931,345	220,329.00	103,355.68	**116,973.32**	275,411.00	131,316.29	**144,094.71**	248,037.00	120,424.27	**127,612.73**	174,427.00	105,347.58	**69,079.42**	13,140.74	**457,760**
	TOTAL	**16,555,831**	3,925,865.64	1,844,895.41	**2,080,970.23**	4,914,858.14	2,347,741.76	**2,567,116.38**	4,454,072.91	2,147,725.56	**2,306,347.35**	3,026,945.00	1,882,327.21	**1,144,617.79**	234,089.03	**8,099,052**

SOURCE OF FUNDING THROUGH SEPTEMBER 30TH, 2006

Source of funding	Total Budget	Obligation	IR 1	IR 2	IR 3	IR 4	IR 5	Total Expenses	Remaining budget	Remaining Obligation	percentage of budget
Family Planning	$ 5,903,830.00	$ 3,626,220.00	$ 456,621.07	$ 850,380.11	$ 732,095.80	$ 506,224.82		$ 2,545,321.80	$ 3,358,508.20	$ 1,080,898.20	36%
Primary Causes of mortality and morbidity	$ 4,085,211.00	$ 2,276,030.00	$ 638,350.02	$ 628,801.58	$ 495,694.95	$ 489,375.66		$ 2,252,222.21	$ 1,832,988.79	$ 23,807.79	25%
Polio	$ 300,000.00	$ 150,000.00	$ 11,109.87	$ 77,997.78	$ 19,484.89	$ 14,732.49		$ 123,325.03	$ 176,674.97	$ 26,674.97	2%
Micro Nutrients	$ 1,240,000.00	$ 800,000.00	$ 144,224.76	$ 286,280.82	$ 185,501.99	$ 205,666.54		$ 821,674.11	$ 418,325.89	$ (21,674.11)	7%
Infectious diseases/Malaria	$ 1,915,000.00	$ 1,415,000.00	$ 304,963.80	$ 345,393.96	$ 348,028.26	$ 351,961.42		$ 1,350,347.44	$ 564,652.56	$ 64,652.56	12%
HIV/AIDS	$ 3,111,790.00	$ 1,144,400.00	$ 289,625.89	$ 158,887.49	$ 366,919.66	$ 314,366.30	$ 234,089.03	$ 1,363,888.37	$ 1,747,901.63	$ (219,488.37)	19%
TOTAL	$ 16,555,831.00	$ 9,411,650.00	$ 1,844,895.41	$ 2,347,741.74	$ 2,147,725.55	$ 1,882,327.23	$ 234,089.03	$ 8,456,778.96	$ 8,099,052.04	$ 954,871.04	100%

CHAPTER TEN

LESSONS LEARNED AND BEST PRACTICES

During Santénet's second year of implementation, many best practices were identified and tested, while lessons from implementation are learned every day. These important lessons detailed below will influence and inform future activities.

SIMULATANEOUS IMPLEMENTATION OF COMPLEMENTARY APPROACHES TO A) INCREASE DEMAND, B) INCREASE AVAILABILITY, AND C) INCREASE QUALITY OF PRODUCTS AND SERVICES CREATES OPTIMAL SYNERGY AND GREATER IMPACT

During year two, Santénet found that simultaneously implementing complementary approaches to improve health created greater impact than implementing an approach alone. The 81 communes utilizing the *Kaominina Mendrika* mobilization approach targeted demand creation and product availability through community-based health workers and distribution agents. Similarly, the PQI approach was introduced in 55 communes at the health center level to improve the quality of service delivery. Initial results from the survey conducted by USAID showed better results in communes where the *Kaominina Mendrika* and PQI approaches were introduced simultaneously. Based on these findings, Santénet will scale up *Kaominina Mendrika* and PQI approaches simultaneously in Y3 in an additional 220 communes.

In March 2007, Santénet will conduct an evaluation of the *mutuelles* program rolled out in Fianarantsoa, which reduces economic barriers to seeking healthcare, thereby increasing access. This evaluation will measure the increase impact of the *mutuelles* in addition to the impact of the *Kaominina Mendrika* and PQI approaches, as all three are being implemented simulaneously. Based on the results, the *mutuelles* will be scaled up to similarly complement KM and PQI.

Finally, Santénet will introduce the *Ankoay* Sport approach in 18 communes where other approaches are already being introduced. Santénet expects to find similar synergies and will perform comparative evaluation analysis at the end of Y3 to demonstrate any added value and increased synergies by the implementation of multiple approaches in a given commune.

SCALE UP OF THE KAOMININA MENDRIKA APPROACH REQUIRES THAT IMPLEMENTING PARTNERS USE THE APPROACH AS A TOOL TO ACHIEVE BETTER RESULTS WHERE THEY ARE ALREADY IMPLEMENTING OTHER PROJECTS AND ACTIVITIES

Through the first cycle of implementation, Santénet learned that scaling up the use of the KM approach in new communes and continuing its implementation in current communes requires that implementing partners use the approach to achieve better results where they are already implementing other projects.

The average KM implementation cost during the first year of the program averaged $12,000 per commune. Many implementing partners initially suggested that this level of funding was not sufficient and budget increases would be required to continue the implementation of the KM approach in future communes.

In this light, Santénet was faced with the double challenge of both increasing the number of communes where the approach would be implemented and ensure that it continue to be in the Cycle1 communes. In order to meet this challenge, implementing partners would have to use the KM approach as a tool to achieve their objectives where they had on going activities already funded by other projects and donors.

In preparation for KM Cycle 2, Santénet assumed that this was possible and provided instructions to partners for developing of their Cycle 2 proposals. This included three, non-negotiable, financial parameters: 1) the total amount of the financial proposal for Cycle 2 could not exceed Cycle 1 total funding, 2) the same number of new communes would implemented as Cycle 1 communes, and 3) a second year of KM implementation would be required in the Cycle 1 communes.

All partners were able to meet these parameters and in fact many have proposed a larger number of new communes, and some with a reduced level of funding.

After one year of implementation, partners have found ways to use the KM approach as a tool to implement other projects and achieve better results. All Title II partners and many Voahary Salama members are planning of using the approach in more communes with less funding per communes. They have created synergies between their projects resulting in economies of scale and scope. This collaboration is leading Santénet to achieve and surpass its objective of implementing KM in 300 communes, 81 of which will have been implemented for a second cycle.

HEALTH DISTRICT PARTICIPATION AND COMMITMENT TO ACTIVITIES AT THE COMMUNE LEVEL FURTHER INCREASE DEMAND, AVAILABILITY AND QUALITY OF HEALTH PRODUCTS AND SERVICES

Increasing demand, availability, and quality of health services and products at the commune level requires the active participation and commitment of the health district. The health district team must be involved throughout implementation to ensure buy-in and involvement of key community leaders.

CBHCs depend on their respective health districts to improve health infrastructure, supply, and maintenance of medical equipment, and sustained provision of essential drugs and consumables. The active participation of the Médecins Inspectors and their teams will provide necessary support to the health center, thereby facilitating positive changes and improvements. This year Médecins Inspectors were asked to review the *Kaominina Mendrika* self-evaluation report as one of the final steps to achieving KM status. Their desire and willingness to participate has resulted in a change to the KM methodology that engages the district teams at the beginning of the process to approve the objectives set by communes.

To facilitate buy-in and involvement of district health officials, Santénet believes that it will be more productive to implement the KM and PQI approaches in all the communes of one district – creating a *Distrika Mendrika*. This will harmonize the approach across a district, and improve impact in a concentrated geographic area.

THE IMPLEMNTATION OF THE MULTISECTORAL KAOMININA MENDRIKA APROACH REQUIRES FLEXIBILITY AND ADAPTATION OF METHODOLOGIES, TOOLS, TIMING AND CHOICE OF IMPLEMENTING PARTNERS.

By working with partners across sectors of development (environmental protection, economic growth and democracy and governance) in the implementation and scale up of the KM approach, Santénet found that

multisectoral integration at the commune level requires flexibility in the application of methodologies, use of tools, timing of activities, and choice of implementing partners.

USAID has created the KM and CAC task force to support the development of an integrated approach. To date, the task force has contributed to the development and finalization of a generic methodology guide and a new version of the health technical guide. The environment and rural development technical guides are also under development, as is the addition of education as a new technical area. In collaboration with the Ministry of Education, the education technical guide has been drafted and a new star has been added to the logo. The new silver star (which represents "grey matter") will be the fifth star of the KM approach.

BUILDING SYSTEMS FOR DATA FOR DECISION MAKING CAN PROFOUNDLY IMPACT PROGRAM PERFORMANCE

This year Santénet worked to improve the HMIS systems in Madagascar to ensure the collection and availability of quality information, knowing that program performance will be improved by building capacity for systematic use of data for decision-making.

Historically, Madagascar's FP program management was highly centralized and the system did not encourage innovation at lower levels. As a consequence, the program stagnated over time and was often unresponsive to beneficiaries' needs. Despite its vertical, top-down approach, the FP program did produce several impressive results over the past decade but persistently struggled to adapt its program to local contexts and needs.

To give the program the flexibility to flourish in a diverse set of local contexts, the new FP strategy targeted local managers for training and empowerment, promoted the use of data for decision making, reinforced team processes for identifying problems, strategic planning, innovation approaches to implementation, and inclusive monitoring and supervision. Immediately following these changes, the MOH/FP local level staff responded with reinvigorated enthusiasm and a renewed commitment. As a result, contraceptive distribution was successfully integrated into essential drugs supply chain management. All indicators show a decrease in contraceptives stock outages and a steady increase in contraceptive use. Staffs are now motivated to this information to continue to make the right decisions and obtain visible and measurable results. They are empowered to do more and to do it better.

COMMUNITY INVOLVEMENT AND POLITICAL SUPPORT ARE NECESSARY TO EFFECTIVELY PROMOTE FAMILY PLANNING

Through implementing several approaches to increase the use of and access to family planning, Santénet learned that partnerships and community involvement are powerful ways to support this. To be effective, new FP strategies in Madagascar must receive strong political support.

The RRI for FP gave MOH/FP officials the opportunity to reach out to communities and engage local stakeholders to increase the use of family planning services. At the same time, the USAID Flexible Fund and Santénet provided grants to Faith Based Organizations and the network of Voahary Salama NGOs to create linkages between community mobilization and the family planning program. While the short-term health effects of these interventions are geographically limited, this example of public-private partnership and the link created between the community health workers and the local health centers will continue to be scaled-up and be key success factors in sustaining the FP program.

While much can be accomplished through a new strategy to improve performance of the FP program, to be truly effective it must be accompanied by national and sub-national level policy support. Political support from the highest level was instrumental in boosting performance from the FP program's decentralized management. The President of Madagascar has taken the lead to promote family planning and made it a priority to reduce poverty within the MAP.

MOH/FP PERSONNEL FIND ENGAGING AND PRATICAL TRAININGS USEFUL

This year trainees and key MOH/FP personnel at the central and district levels gave highly positive feedback about Santénet-sponsored training activities. Participants noted that all training activities were practical and built on the competency of participants, empowering them to be more creative and more confident to undertake new initiatives and make changes in their daily work.

One example is that of the chief of the CBHC in Isotry Central CBHC. After attending a training implemented by Santénet in infection prevention, he took the initiative to expand the IP education to HIV/AIDS prevention efforts among the hairdressers working in poor neighborhoods in his district.

CHALLENGES CAN BE OVERCOME THROUGH ADVOCACY AND EXCHANGE

Through advocacy and exchange of experiences, Santénet found that challenges can be overcome through greater understanding and cooperation. This year Santénet advocated strongly among the ministry and local governments to introduce the PQI approach and the SDM in Madagascar. These actions helped to launch the institutionalization process of the PQI and brought support from other donors for the national expansion of SDM.

ENSURING SUSTAINABILITY OF THE PQI APROACH REQUIRES ADAPTATION FOR RURAL CBHCS AND SEAMLESS INTEGRATION INTO THE MOH/FP'S QUALITY ASSURANCE SYSTEM

In introducing the PQI approach this year, Santenet learned that it needs be adapted to the context of rural CBHCs and that it should be integrated in the MOH/FP Quality Assurance System, in order to ensure that it is sustainable.

Norms and criteria of the PQI methodology and tools must be revised for rural CBHCs in order to: a) reflect basic realities, b) ensure feasibility, and c) reduce the amount of time necessary for performing the initial and follow-on evaluations. The package of norms and criteria used in the initial training sites, although optimal and technically sound, has proven to be, in part, not applicable in the rural context. Resulting long lists of non applicable norms and criteria burden the process, and initial low levels of achievement discourage health service providers. Santenet is now beginning the process of striking the balance between streamlining the tools to minimize burden and maximize results, and keep a high level of quality.

For sustainability, the MOH/FP must take full ownership of the PQI approach and use it as the foundation of its QAS. The approach requires the commitment and involvement of all levels of Ministry staff to be effective. CBHCs depend on the ministry system for provision of infrastructure, equipment, qualified personnel, drugs and consumables; all of which are necessary to improve performance and quality. Another vital element to the sustainability of the PQI approach is the buy-in and use by the Médecins Inspectors as an improved supervision tool. Furthermore it must be integrated into all levels of MOH/FP monitoring systems. The initial evaluation allows the local team and their supervisors to better identify actual problems and the action plan provides a clear road map to solve them. Monitoring progress towards the accomplishment of the work plan makes supervisory visits more objective and productive. To reach scale in the use of the PQI approach, the MOH/FP must systematize the use and take full ownership of the approach.

CHAPTER ELEVEN

PERSPECTIVES FOR 2006 – 2007

The activities described in this report set the stage for the project's third year, when Santénet will launch Cycle 2 of the *Kaominina Mendrika*, scale up the PQI approach, *mutuelles* and other health financing schemes, and continue to build capacity within the Malagasy health system.

SPECIFIC ACTIVITIES PLANNED FOR INTERMEDIATE RESULT 1

During years one and two, Santénet developed approaches and supported structures to promote behavioral change. The team will build on these experiences in Y3, refining and scaling up community mobilization approaches while strengthening the MOH/FP's IEC/BCC and social mobilization activities. Several activities will strengthen the MOH/FP's IEC/BCC and social mobilization components. Specifically, Santénet will support the Health Promotion Division in developing the National Health Promotion Policy that articulates the MOH/FP's vision for health promotion and a partnership framework. Santénet will also continue to support the MOH/FP's IECSMU in its leadership role in IEC and social mobilization, positioning the unit to be fully operational when the National Health Promotion Policy is finalized. In addition, Santénet will support the different units within the MOH/FP in developing communication strategies and implementing IEC/BCC and social mobilization activities. The project will support the RH/SMU in implementing the National FP Communication Strategy in support of the new National FP Strategy.

At the community level, Santénet will scale up or strengthen community mobilization activities to promote behavioral change. Specifically, the project will complete the first cycle of KM in the first 81 communes and launch the second cycle in those communes and in 180 additional communes. To maximize results, the commune selection will be geographically concentrated in nine health districts, and programmatically where other community mobilization approaches and IEC/BCC activities are scaling up. For instance, Santénet will scale up the *Ankoay* approach with the scouts, junior high schools, and sports clubs in health districts which have KM communes. Santénet will also scale up HIV/AIDS awareness-raising activities using hairdressers as peer educators for high-risk groups. The KM approach will provide a platform for Santénet to collaborate with the NNO to implement the National Community-based Nutrition Program (NCNP) in a number of NNOs pilot communes. Finally, Santénet will undertake more intensive efforts to promote family planning in the KM communes located in or around the forest corridor.

SPECIFIC ACTIVITIES PLANNED FOR INTERMEDIATE RESULT 2

In the next year, the IR2 team will continue to work in the areas of promoting family planning, improving child health, improving access to socially marketed products, and the supporting health system in non-clinical ways.

Santénet will support the implementation of the FP strategy, community-level service provision, and public sector contraceptive supply chain. It will provide technical assistance in forecasting contraceptive commodity needs, contribute to the FP program coordination, and contribute to improving FP service provision.

In the area of child health, Santénet will participate in the EPI technical and senior IACC committees, build health worker management skills, ensure efficient logistics, and strengthen M&E systems to improve EPI.

Additionally data management quality will be improved through Santénet's technical assistance in IT, and by it's participation in surveillance of the scheduled campaigns for Maternal and Neonatal Tetanus (MNT), measles, and polio vaccination. Furthermore the IR2 team will provide technical assistance to the malaria control program and support public sector logistics for distributing STI kits.

To increase access and availability of social marketing products, Santénet will support the continued expansion of private and NGO distribution networks, ensuring product availability and building on the successes of the first two years of the project. Santénet will work to expand the private and NGO distribution channels for social marketing products, support implementation of the basic health coverage by supporting the establishment of a hospital-level Equity Fund, and expand and monitor community-based health financing (*mutuelles*).

Santénet will improve health through the non-clinical means by bolstering the nutritional value of agricultural commodities and improving access to clean water. This will occur by supporting the demonstration plots for the cultivation orange-fleshed sweet potato, and by participation in the HIP initiative to improve water management for agricultural and home use.

SPECIFIC ACTIVITIES PLANNED FOR INTERMEDIATE RESULT 3

Santénet will continue to work to improve service quality in accordance with evidence-based standards and guidelines. In project Y3, the project will reinforce achievements of the first two years through regular monitoring and will pursue its effort to improve quality at the national, district, and community levels. IR3 will support the MOH/FP to finalize the updated RH policy and disseminate the RH standards and procedures at national and regional levels.

To support in-service training, Santénet will utilize the trainers trained in 2006 to update the CBHC providers in the nine districts participating in *Distrika Mendrika*. This will allow providers to offer high-quality services based on performance standards. Furthermore, Santénet will certify 20 master trainers who will update the in-service training STI/HIV training module and the IMCNI facilitators' guide. In addition, many clinical trainers (57 trained in 2006) will train KM CBHCs providers. The project will support the design of promotional materials for clinical training services, and disseminate the names of certified trainers to health institutions. Santénet will also explore ways to incorporate the pool of trainers from the Family Health Directorate, the Malaria Control Unit, the STI/AIDS program and the Training Unit at the MOH/FP.

For pre-service training, Santénet will monitor the use of teaching materials and the implementation of action plans developed in 2006. In 2006-07, the IR3 team will establish linkages between practicum sites and faculty at the medical and paramedical schools. The newly approved IMCNI protocol will be used in training and supervising students.

Santénet will work with the MOH/FP Quality Coordination Unit to approve standards developed by Santénet for IP, FP, STI, and FPC/IPT to scale up QAS across Madagascar. Santénet will conduct joint monitoring visits to the established QAS sites facilitating the first certification of health facilities in IP in 2006-07.

The QAS system will be scaled up in nine *Distrika Mendrika*. Each district will have a trained evaluation team to facilitate the baseline performance assessment, gap analysis, and development of action plans to address problems. In new districts, the technical QAS modules will be rolled out in phases to facilitate the application of standards by providers. Finally, Santénet will provide support in procuring IP kits,

including chlorine-generating machines for the district-level hospitals.

Following the successful introduction of SDM in Madagascar, the MOH/FP has approved its national scaling up, incorporating SDM in the RH standards and procedures and in the FP training module. Santénet will continue to support the MOH/FP to expand the method to nine selected districts.

SPECIFIC ACTIVITIES PLANNED FOR INTERMEDIATE RESULT 4

In the next fiscal year, Santénet will continue to work to develop the capacity of local Malagasy organizations and systems to provide and advocate for health.

The project will assist in disseminating tools for systems management, namely the FP register and the outpatient consultation register, in developing the national HIS strategy, funding and supporting training in MIS/DDM for regional trainers and for the CBHC in the new KM communes. The IR4 team will also support the MOH/FP to inculcate a culture of information sharing through a series of information exchange meetings.

Santénet will help the MOH/FP in implementing activities related to the National Contracting Policy, given its significant implications on the relationship between NGOs and MOH/FP in implementing health programs. Santénet will also support the FP partnership to better coordinate their interventions and achieve greater impact.

Santénet will work with partner NGOs to build their institutional capacities while implementing the KM approach. To strengthen civil society's capacity for advocating for health, Santénet will support the network of faith-based organizations in implementing their program under the new FP strategy and the faith-based organizations' platform PLeROC in carrying out their STI/AIDS control programs.

ANNEXES

KM INDICATORS ACHIEVED FOR THE 25 CERTIFIED COMMUNES

	ONG	Communes	Utilisateurs réguliers PF								
			Données de base	Objectif fin du cycle	Situation en fin du cycle	Pourcentage d'augmentation par rapport à situation de base	Taux de réalisation	Population totale	Population cible (23%)	Taux de couverture en début du cycle	Taux de couverture contraceptive à la fin du cycle
1	ADRA	Amboasary	608	694	734	120.72%	105.76%	12,465	2867	21.2	25.6
2	ADRA	Ampasimpotsy Gara	77	128	179	232.47%	139.84%	7,371	1695	4.5	10.6
3	ADRA	Anosibe An'ala	53	202	212	400.00%	104.95%	21,030	4837	1.1	4.4
4	ADRA	Anosibe Ifody	414	476	478	115.46%	100.42%	3,199	736	56.3	65.0
5	ADRA	Vodiriana	387	387	436	112.66%	112.66%	6,895	1586	24.4	27.5
6	MCDI	Bezaha	100	220	498	498.00%	226.36%	17,337	3988	2.5	12.5
7	MCDI	Ambatry	12	36	66	550.00%	183.33%	12,278	2824	0.4	2.3
8	MCDI	Belamoty	34	150	476	1400.00%	317.33%	15,118	3477	1.0	13.7
9	MCDI	Mahaboboka	21	100	103	490.48%	103.00%	7,461	1716	1.2	6.0
10	MCDI	Ankazomanga	89	120	245	275.28%	204.17%	4,323	994	9.0	24.6
11	MCDI	Maromiandra	23	80	82	356.52%	102.50%	7,008	1612	1.4	5.1
12	MCDI	Vineta	25	100	191	764.00%	191.00%	6,663	1532	1.6	12.5
13	MCDI	St Augustin	126	190	281	223.02%	147.89%	12,192	2804	4.5	10.0
14	MCDI	Andranovory	56	150	191	341.07%	127.33%	12,635	2906	1.9	6.6
15	CARE	Tsivangiana	283	371	394	139.22%	106.20%	11,972	2754	10.3	14.3
16	CARE	Mahela	10	91	66	660.00%	72.53%	11,692	2689	0.4	2.5
17	CARE	Amboditavolo	214	334	423	197.66%	126.65%	7,209	1658	12.9	25.5
18	CARE	Tsaravinany	ND	152	184	NA	121.05%	19,794	4553	NA	4.0
19	CARE	Ampasina Maningory	852	1131	1290	151.41%	114.06%	40,449	9303	9.2	13.9
20	CARE	Betsizaraina	159	324	418	262.89%	129.01%	23,947	5508	2.9	7.6
21	CARE	Ambodiharana	ND	174	315	NA	181.03%	22,420	5157	NA	6.1
22	AINGA	Ambohimiera	179	450	620	346.37%	137.78%	16,732	3848	4.7	16.1
23	AINGA	Tsaratanana	114	640	609	534.21%	95.16%	23,326	5365	2.1	11.4
24	AINGA	Ranomafana	339	999	470	138.64%	47.05%	12,057	2773	12.2	16.9
25	AINGA	Antaretra	63	223	249	395.24%	111.66%	12,680	2916	2.2	8.5
SYNTHESE			4238	7922	9210	217.32%	116.26%	348,253	80,098	**5.3**	**11.5**

	ONG	Communes	Une Consultation Prénatale (nouvelles inscrites)							
			Données de base	Objectif fin du cycle	Situation en fin du cycle	Pourcentage d'augmentation par rapport à situation de base	Taux de réalisation	Population cible (4,5%)	Taux de couverture contraceptive en début du cycle	Taux de couverture à la fin du cycle
1	ADRA	Amboasary	310	350	356	114.84%	101.71%	561	55.3	63.5
2	ADRA	Ampasimpotsy Gara	132	200	203	153.79%	101.50%	332	39.8	61.2
3	ADRA	Anosibe An'ala	264	688	894	338.64%	129.94%	946	27.9	94.5
4	ADRA	Anosibe Ifody	121	121	158	130.58%	130.58%	144	84.1	109.8
5	ADRA	Vodiriana	311	311	317	101.93%	101.93%	310	100.2	102.2
6	MCDI	Bezaha	429	540	557	129.84%	103.15%	780	55.0	71.4
7	MCDI	Ambatry	37	100	128	345.95%	128.00%	553	6.7	23.2
8	MCDI	Belamoty	582	750	644	110.65%	85.87%	680	85.5	94.7
9	MCDI	Mahaboboka	41	303	322	785.37%	106.27%	336	12.2	95.9
10	MCDI	Ankazomanga	86	140	151	175.58%	107.86%	195	44.2	77.6
11	MCDI	Maromiandra	44	250	294	668.18%	117.60%	315	14.0	93.2
12	MCDI	Vineta	190	280	433	227.89%	154.64%	300	63.4	144.4
13	MCDI	St Augustin	263	362	411	156.27%	113.54%	549	47.9	74.9
14	MCDI	Andranovory	125	425	620	496.00%	145.88%	569	22.0	109.0
15	CARE	Tsivangiana	414	445	728	175.85%	163.60%	539	76.8	135.1
16	CARE	Mahela	16	95	319	1993.75%	335.79%	526	3.0	60.6
17	CARE	Amboditavolo	ND	347	436	NA	125.65%	324	NA	134.4
18	CARE	Tsaravinany	ND	350	357	NA	102.00%	891	NA	40.1
19	CARE	Ampasina Maningory	407	597	961	236.12%	160.97%	1820	22.4	52.8
20	CARE	Betsizaraina	ND	765	924	NA	120.78%	1078	NA	85.7
21	CARE	Ambodiharana	429	525	537	125.17%	102.29%	1009	42.5	53.2
22	AINGA	Ambohimiera	402	422	428	106.47%	101.42%	753	53.4	56.8
23	AINGA	Tsaratanana	468	588	619	132.26%	105.27%	1050	44.6	59.0
24	AINGA	Ranomafana	ND	380	325	NA	85.53%	543	NA	59.9
25	AINGA	Antaretra	288	320	367	127.43%	114.69%	571	50.5	64.3
SYNTHESE			5359	9654	11489	214.39%	119.01%	15671	**34.2**	**73.3**

	ONG	Communes	VAT 2 et plus							
			Données de base	Objectif fin du cycle	Situation en fin du cycle	Pourcentage d'augmentation par rapport à situation de base	Taux de réalisation	Population cible (4,5%)	Taux de couverture contraceptive en début du cycle	Taux de couverture à la fin du cycle
1	ADRA	Amboasary	156	300	481	308.33%	160.33%	561	27.8	85.8
2	ADRA	Ampasimpotsy Gara	108	221	239	221.30%	108.14%	332	32.6	72.1
3	ADRA	Anosibe An'ala	240	645	680	283.33%	105.43%	946	25.4	71.9
4	ADRA	Anosibe Ifody	35	125	169	482.86%	135.20%	144	24.3	117.4
5	ADRA	Vodiriana	317	317	408	128.71%	128.71%	310	102.2	131.5
6	MCDI	Bezaha	61	486	717	1175.41%	147.53%	780	7.8	91.9
7	MCDI	Ambatry	37	90	107	289.19%	118.89%	553	6.7	19.4
8	MCDI	Belamoty	337	679	1056	313.35%	155.52%	680	49.5	155.2
9	MCDI	Mahaboboka	28	273	283	1010.71%	103.66%	336	8.3	84.3
10	MCDI	Ankazomanga	109	130	362	332.11%	278.46%	195	56.0	186.1
11	MCDI	Maromiandra	59	250	375	635.59%	150.00%	315	18.7	118.9
12	MCDI	Vineta	133	252	430	323.31%	170.63%	300	44.4	143.4
13	MCDI	St Augustin	135	345	421	311.85%	122.03%	549	24.6	76.7
14	MCDI	Andranovory	53	383	561	1058.49%	146.48%	569	9.3	98.7
15	CARE	Tsivangiana	364	410	519	142.58%	126.59%	539	67.6	96.3
16	CARE	Mahela	53	71	220	415.09%	309.86%	526	10.1	41.8
17	CARE	Amboditavolo	ND	347	348	NA	100.29%	324	NA	107.3
18	CARE	Tsaravinany	218	449	448	205.50%	99.78%	891	24.5	50.3
19	CARE	Ampasina Maningory	379	561	1031	272.03%	183.78%	1820	20.8	56.6
20	CARE	Betsizaraina	ND	573	958	NA	167.19%	1078	NA	88.9
21	CARE	Ambodiharana	ND	420	512	NA	121.90%	1009	NA	50.7
22	AINGA	Ambohimiera	ND	502	4108	NA	818.33%	753	NA	545.6
23	AINGA	Tsaratanana	620	701	2794	450.65%	398.57%	1050	59.1	266.2
24	AINGA	Ranomafana	ND	385	779	NA	202.34%	543	NA	143.6
25	AINGA	Antaretra	ND	380	428	NA	112.63%	571	NA	75.0
SYNTHESE			3442	9295	18434	535.56%	198.32%	15671	**22.0**	**117.6**

	ONG	Communes	DTCHepB3							
			Données de base	Objectif fin du cycle	Situation en fin du cycle	Pourcentage d'augmentation par rapport à situation de base	Taux de réalisation	Population cible (4%)	Taux de couverture contraceptive en début du cycle	Taux de couverture à la fin du cycle
1	ADRA	Amboasary	252	399	413	163.89%	103.51%	499	50.5	82.8
2	ADRA	Ampasimpotsy Gara	132	236	266	201.52%	112.71%	295	44.8	90.2
3	ADRA	Anosibe An'ala	360	688	889	246.94%	129.22%	841	42.8	105.7
4	ADRA	Anosibe Ifody	110	138	201	182.73%	145.65%	128	86.0	157.1
5	ADRA	Vodiriana	254	276	279	109.84%	101.09%	276	92.1	101.2
6	MCDI	Bezaha	94	270	285	303.19%	105.56%	693	13.6	41.1
7	MCDI	Ambatry	32	100	122	381.25%	122.00%	491	6.5	24.8
8	MCDI	Belamoty	325	500	494	152.00%	98.80%	605	53.7	81.7
9	MCDI	Mahaboboka	34	312	315	926.47%	100.96%	298	11.4	105.5
10	MCDI	Ankazomanga	49	130	139	283.67%	106.92%	173	28.3	80.4
11	MCDI	Maromiandra	158	250	316	200.00%	126.40%	280	56.4	112.7
12	MCDI	Vineta	161	274	299	185.71%	109.12%	267	60.4	112.2
13	MCDI	St Augustin	190	300	318	167.37%	106.00%	488	39.0	65.2
14	MCDI	Andranovory	206	340	371	180.10%	109.12%	505	40.8	73.4
15	CARE	Tsivangiana	124	410	622	501.61%	151.71%	479	25.9	129.9
16	CARE	Mahela	211	374	424	200.95%	113.37%	468	45.1	90.7
17	CARE	Amboditavolo	ND	208	280	NA	134.62%	288	NA	97.1
18	CARE	Tsaravinany	383	581	587	153.26%	101.03%	792	48.4	74.1
19	CARE	Ampasina Maningory	498	1294	1353	271.69%	104.56%	1618	30.8	83.6
20	CARE	Betsizaraina	1054	1293	1381	131.02%	106.81%	958	110.0	144.2
21	CARE	Ambodiharana	320	544	681	212.81%	125.18%	897	35.7	75.9
22	AINGA	Ambohimiera	ND	535	734	NA	137.20%	669	NA	109.7
23	AINGA	Tsaratanana	240	690	691	287.92%	100.14%	933	25.7	74.1
24	AINGA	Ranomafana	ND	363	341	NA	93.94%	482	NA	70.7
25	AINGA	Antaretra	156	380	515		135.53%	507	30.8	101.5
SYNTHESE			5343	10885	12316	230.51%	113.15%	13930	**38.4**	**88.4**